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Health Care Leadership: Emotional Intelligence Competencies of Hospitalist Leaders

Michael Albert Cherry
Olivet Nazarene University, mcherry@olivet.edu

HEALTH CARE LEADERSHIP:

EMOTIONAL INTELLIGENCE COMPETENCIES OF HOSPITALIST LEADERS

BY

MICHAEL ALBERT CHERRY

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MICHAEL ALBERT CHERRY

Dissertation

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DEDICATION

To Allison, Owen, Sean, and Liam.

ABSTRACT

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Michael Albert Cherry, Ed.D.
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The challenges facing the United States healthcare system continue to evolve and raise expectations for physician leaders. These leaders serve at the intersection of clinical care and business realities and thus have the ability to influence improvement in healthcare quality and business performance. The purpose of this study was to determine hospitalist medical directors' performance on emotional intelligence (EI) competencies and their perceptions of the importance of these competencies to their leadership role. This quantitative study used a correlation research methodology. The results did not suggest strong correlations between self-reported EI competencies and hospitalist medical directors' perceptions of their leadership role. Further research is suggested to include multi-rater assessment and objective performance data rather that self reported perceptions.

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CHAPTER I

INTRODUCTION

The national debate regarding the state of the healthcare system in the United States is decades old. Several administrations and most recently President Obama have targeted healthcare reform as a top initiative. Consequently, the United States healthcare system is viewed by many as broken (Kirchhemer, 2008; Wachter, 2004a). Concerns about the healthcare environment include: the rising costs for individuals, businesses and hospitals, lack of access, the advent of managed care, the increased importance and visibility of hospital performance metrics, the influence exerted by insurance companies on care decisions, union relations, and greater media coverage and scrutiny related to the quality of care and ethics have kept the debate in the forefront.

As the healthcare environment continues to gain complexity, the past practices of physician leaders may no longer be effective (Beckham, 1995). Physician leaders are being challenged to change, adapt and improve their approach to effectively lead their organizations (McAlearney, Fisher, Heiser, Robbins, & Kelleher, 2005). As a result, many physician leaders are not prepared for the current leadership demands of their roles (Kaplan & Feldman, 2008).

This researcher has participated in numerous physician leader coaching engagements since 2002. One particular group, hospitalist medical directors, are seeking

coaching with increasing frequency. Hospitalists are physicians who specialize in inpatient medicine and manage the care of hospitalized patients (Wachter & Goldman, 1996) and a hospitalist medical director leads a hospitalist program within an organization. Through an analysis of the strengths and areas of improvement as articulated by physician leaders and those who they lead, this researcher believes that one method for improving some facets of the healthcare system in the United States is by enhancing the leadership acumen of hospitalist medical directors.

Statement of the Problem

The challenges facing the healthcare system in the United States have raised expectations for physician leaders to direct their organizations more effectively and efficiently (Beckham, 1995). Physician leadership is essential because these leaders serve at the intersection of clinical care and business realities (Gerbarg, 2002). Deficient leadership negatively impacts the organization, which can lead to lower performance of the hospital and can impact the performance of the healthcare industry (Greeno, 2003). The purpose of this study was to determine hospitalist medical directors' performance on emotional intelligence (EI) competencies and their perceptions of the importance of these competencies to their leadership role.

Background

Healthcare organizations have explored new care models to improve performance on such metrics as length of stay, quality of care, and patient satisfaction. One model included the establishment of the hospitalist specialty. Wachter and Goldman (1996) first coined the term "hospitalist." A hospitalist treats patients in a hospital setting rather than an outpatient setting. Hospitalists, generally, do not have their own private practices;

rather they care for patients referred to them by primary care providers (PCP). Upon completing the needed medical procedures and discharge from the hospital, the patients will return to their PCP for follow-up care and health maintenance.

The hospitalist specialty has proven to be effective in two key areas of hospital performance, reduction in the length of stay and improvement in the quality of care (Auerbach et al., 2002; Diamond, Goldberg, & Janosky, 1998; Freese, 1999). These metrics have increased in importance as hospital performance has gained greater visibility through the implementation of Press-Ganey measurements. Press-Ganey (2009) has become an industry standard for measuring hospital performance and has been noted in the ranking of hospital excellence. For example, eight out of nine recipients of the 2009 Malcolm Baldrige National Quality Award, 57% of the recipients of the 2007 Consumer Choice Award, 9 of 11 health care providers on Fortune's 100 Best Companies to Work for in 2007, 9 out of 14 recipients of the National Quality Health Care Award, and 63% of the 2007 U.S. News & World Report ranking of America's Best Hospitals utilize the Press-Ganey methodologies and measures (Press-Ganey). As hospital performance has become more visible and the marketing of high performing hospitals broadens, the hospitalist specialty became the fastest growing specialty in the history of modern medicine (Wachter, 2007) because of its ability to reduce length of stay and improve the quality of patient care. The Society of Hospital Medicine (SHM) (2008) estimates 21,600 hospitalists are currently practicing in the United States.

As the adoption of hospitalists has grown, the need for skilled leadership for hospitalist programs has also grown (Levey, Hill, & Greene, 2002; Saint & Flanders, 2004). Some hospitalist physicians assume the role of medical director of a hospitalist

program. These medical directors have spent years in school to learn the delivery of care and medicine however most have not been exposed, in their academic experience, to any formal leadership, management, or business concepts. As medical directors however, they are being held accountable for these leadership responsibilities by their healthcare organization (Blankenbaker, Fletcher, & Helms, 1999; Dressler, Pistoria, Budnitz, McKean, & Amin, 2006; Harrison & Ogniewski, 2004). As physicians transition into leadership roles, there are subtle but clear distinctions in the expectations of a leadership role (Kaplan & Feldman, 2008; Zaher, 1996). Physicians must now think of themselves as executives who happen to be physicians rather than physicians who happen to be executives.

Physicians often continue in dual roles as both clinical providers and business leaders, which can be challenging for a variety of reasons. For example, physicians work autonomously and independently while leaders work with teams and emphasize collaboration. Physicians operate with tangible, direct, concrete and clear metrics for success while leaders must address chronic ambiguity and extended time frames (Gill & Lambert, 2004). What may be most challenging for physician leaders is balancing the focus on the delivery of care within organizational objectives.

Hospitalist medical directors face similar dilemmas and are uniquely challenged because they interact with a wide variety of stakeholders. Stakeholders can include: patients, patients' families, PCPs, nurses, hospital administrators, consulting physicians, hospitalist physician colleagues, post-acute care facility representatives, and insurance organizations (Hauer, Flanders, & Wachter, 1999). To collaborate effectively and build

relationships with these stakeholders there is an increasing need for leadership that demonstrates a strong foundation in emotional intelligence (EI).

The term and concept of EI was presented by Salovey and Mayer (1990) and was popularized by a series of books and articles by Goleman (1995, 1998a, 1998b, 2002, 2006). EI is the ability to recognize one's own emotions, sense emotional input from others, and react appropriately to that input (Noland, 2008). Salovey and Mayer define EI as, "The ability to monitor one's own and others' feelings, to discriminate among them, and to use this information to guide one's thinking and action" (p. 189). Goleman's (2002) definition included four components of EI; (1) self-awareness which is the ability to recognize one's own emotions; (2) self-management which is the ability to control and effectively use one's emotions; (3) social awareness which is the ability to recognize and understand the emotions of others; and (4) relationship management which is the ability to use emotional input in interactions with others. The concept of EI gained popularity through its application in understanding and developing effective leadership practice.

EI has been shown to correlate positively to leadership effectiveness. Boyatzis (1999) found in a study of the financial performance of leaders that, "It is also important to note that both cognitive and emotional intelligence competencies predicted performance. Of course, it is also important to note that 93% (i.e., 13/14) of the competencies predicting performance were from the emotional intelligence clusters" (p. 130). Other researchers have also determined that leaders with high EI scores contribute positively to organizational success. For example, McClelland (1998) found that executives selected based on EI competence in a multinational beverage firm exceeded

their goals by 15 to 20%. Those executives who did not have high EI competence under-performed as compared to those who did, by approximately 20%.

The use of EI has also been linked to positive results in healthcare settings. Through using EI, physicians and caregivers are able to recognize and use emotions to facilitate decision-making. EI has been shown to be critical to the delivery of excellent patient care (Smith, Farmer, Walls, & Gilligan, 2008). The authors stated:

> Traditionally, the terms professionalism or professional behaviors have been used synonymously by educators to imply emotional and social competence. Although there is clear consensus that professional behaviors are important to evaluate, it is also clear that specific performance criteria for self-awareness, initiative, empathy, conflict management, integrity, team management and other professional behaviors are typically missing from the clinical evaluation checklist. (p. 298)

Although EI has been shown to contribute to excellent patient care (Birks & Watt, 2007), much less research has been conducted on the links between EI and physician leaders. There have been no studies, to this researcher's knowledge, that link hospitalist medical directors and the use of EI in their leadership approach.

A fundamental premise of this study is that hospitalist medical directors who perceive that they have a high level of EI may perceive they are better leaders of their programs. Therefore, programs with these types of leaders could be more effective in delivering high quality care, achieving high patient satisfaction while reducing costs and improving the work environment.

Research Questions

1. What are the EI competencies identified as important for leadership by hospitalist medical directors?
2. How do hospitalist medical directors rate their EI performance?
3. How do self-reported EI competencies correlate to hospitalist medical directors perceptions of their leadership role?

Description of Terms

Coaching. A managerial development process using a personal trainer to develop leadership competencies and achieve business results.

Emotional Intelligence. "The ability to monitor one's own and others' feelings, to discriminate among them, and to use this information to guide one's thinking and action." (Salovey & Mayer, 1990, p. 189)

Hospitalist. "A new breed of physicians we call hospitalists, specialists in inpatient medicine, who will be responsible for managing the care of hospitalized patients in the same way that primary care physicians are responsible for managing the care of outpatients" (Wachter & Goldman, 1996, para. 3).

Hospitalist Program. A group of hospitalist physicians who specialize in inpatient medicine and manage the care of hospitalized patients (Wachter & Goldman, 1996).

Inpatient. A hospital patient who receives lodging and food as well as treatment (Merriam-Webster, 2009).

Managed Care. Managed care plans are health insurance plans that contract with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. There are three types of managed care plans.

Health Maintenance Organizations (HMO) usually only pay for care within the network and participants choose a primary care doctor who coordinates most of their care. Preferred Provider Organizations (PPO) usually pay more if participants get care within the network, but they still pay a portion if participants go outside the network. Point of Service (POS) plans let participants choose between an HMO or a PPO each time they need care (MedLine Plus, 2009).

Medical Director. A leader of a group of physicians, department, or specialty area.

Outpatient. A patient who receives treatment at a hospital or clinic without being hospitalized.

Press-Ganey. An organization and an evaluation technique for determining hospital performance.

Primary Care Provider. Primary care is care delivered by providers specifically trained for and skilled in first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings including, physician office, hospital, long-term care facility, etc. Primary care is performed and managed by a personal providers often collaborating with other health professionals. These providers may utilize consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication

with patients and encourages the role of the patient as a partner in health care (American Academy of Family Physicians, 2009).

Significance of the Study

Studies have been conducted that support the link between EI and leadership success (Boyatzis, 1999; Dearborn, 2002; Goleman, 1998a, 1998b). Spencer and Spencer (1993), and Spencer, McClelland, and Kelner (1997) (as cited in Cherniss, 1999) found that sales agents hired using emotional intelligence competencies sold $91,370 more than those sales agents hired not using emotional intelligence competencies. In addition, those sales agents who were selected using emotional intelligence competencies had 63% less turnover during the first year than those agents not selected using emotional intelligence competencies. However, relatively few studies have addressed EI in healthcare environments (Birks & Watt, 2007; Humpel, Caputi, & Martin 2001; Pau & Croucher, 2003; Smith, Farmer, Walls, & Gilligan, 2008; Wagner, Ginger, Grant, Gore, & Owens, 2002) and the literature in support of EI and physician leadership is lacking.

While the studies referenced above focused on leaders from industries other than healthcare, one could expect the results to be similar in a healthcare environment. Leaders who recognize the importance of EI and perform EI competencies at a high level should be more effective. Consequently, those leaders that fail to recognize the importance and perform poorly on EI competencies should be less effective. The variance in EI recognition and performance could be related to factors such as leadership tenure, number of years in an organization, and staff size.

This study created new knowledge in this field based on the population surveyed, hospitalist medical directors, and should assist in the development of and identification of

hospitalist leaders. It is important for hospitalist medical directors to demonstrate effective leadership to achieve optimal organizational performance such as high patient satisfaction at lower financial cost. Through this research, education, training, and orientation for hospitalist medical directors could be altered to include EI topics and competencies. Through the development of these competencies, hospitalist medical directors will be better prepared to lead their programs to achieve positive organizational performance.

Procedure to Accomplish

The author conducted quantitative research using a relational, correlation methodology (Robson, 2002). This study employed purposive sampling and identified 169 hospitalist medical directors who led programs of three or more hospitalist physicians. The hospitalist medical directors were identified from three multistate, outsourced physician services organizations. Based on survey data collected by the Society of Hospital Medicine (SHM) (2008), the 169 hospitalist medical directors identified for this research represent 38% of the hospitalist medical directors leading hospitalist physician groups in multistate, outsourced physician services organizations. The firms were identified as Organization A (29 members) and Organization B (140 members). These organizations contract with hospitals to provide hospitalist programs. The threshold of three or more hospitalist physicians was used based on team research from Katzenbach and Smith (2003). Katzenbach and Smith stated, "Virtually all the teams we have met, read, heard about, or been members of have ranged between two and twenty-five people. The majority of them…have numbered less than ten" (p. 45). The

author received permission from the organizations before surveying the hospitalist medical directors.

The survey instrument adapted for this study was developed by the organization, Six Seconds, The Emotional Intelligence Network is titled the SEI 360 Feedback International Edition (Freedman, 2007b). The author obtained written permission (Appendix A) to adapt this survey. The SEI measured the fundamentals of EI, including emotional literacy, emotional management, and empathy through three competencies. The first pursuit was Know Yourself which involved increasing self-awareness. This competency helps people understand their own thoughts, feelings, and actions. The second pursuit was Choose Yourself which entailed building self-management and self-direction. This competency helps people follow their intentions and live and lead more consciously. The final pursuit was Give Yourself which aligned daily choices with a larger sense of purpose. This assists people to live and lead more effectively, relate meaningfully with others, and achieve their vision/mission (Freedman, 2007b). The SEI 360 Feedback International Edition has been investigated for reliability through factorial analysis and Cronbach's alphas. The adaptations made to the SEI survey were to add a rating scale for importance and reduce the number of questions about personal lifestyle.

The hospitalist medical directors were also asked questions (Appendix B) such as the number of years of experience as a hospitalist medical director, the size and location of the hospital, and the number of years as a physician. The survey instrument was administered via an internet-based survey system. A test was performed to ensure the technology performed as expected (Robson, 2002).

The hospitalist medical directors were emailed a joint introductory letter from the author and a representative from each firm (Appendix C). The email also delivered the intent to participate form that outlined the purpose of the study, time commitment, procedures, that the data would only be used in aggregate form, and sought a preferred email address. Following the return of the intent to participate form the survey was distributed. The opening page of the survey served as the informed consent form (Appendix D). Once participants indicated their consent they were directed to the survey. The survey was conducted over a three week period. After the initial invitation, bi-weekly reminders were sent to participants who did not reply. Participants were informed that a summary of the findings would be available to them upon request.

After the data were collected, the relationship between the hospitalist medical directors' self-perceptions of their leadership role, and the importance of and performance on emotional intelligence competencies were determined. Using correlations the author identified trends in leadership strengths as well as gaps in emotional intelligence skills for the hospitalist medical directors that related to their leadership role. Based on EI research linking EI to improved organizational achievement (Cherniss, 1999), the author hypothesized that positive correlations could be discovered between high EI and improved quality of care and patient satisfaction and reduced length of stay and cost of hospitalization.

The author also hypothesized that positive correlations could be realized between the EI competency Know Yourself and the medical directors' length of tenure as a leader in their organization based on research indicating that EI can be developed over time (Carmeli, Brueller, & Dutton, 2008). The EI competency Choose Yourself, was

hypothesized to be positively correlated to number of years as a hospitalists, number of years at the hospital, and number of years as a hospitalist medical director based on the medical directors' choice of the organization and role. Finally, the EI competency Give Yourself, was believed to be positively correlated to staff size as the use of EI may be needed more frequently when working with a larger staff (Carmeli, 2003).

CHAPTER II: REVIEW OF THE LITERATURE

Introduction

The previous chapter provided an overview of this study. In this chapter, literature regarding the changing landscape of health care in the United States and the changing roles and responsibilities of physician leaders was reviewed. In addition, literature regarding the construct of leadership and EI, as well as, the role of hospitalists was explored.

As review, this study intended to explore hospitalist medical directors' performance on EI competencies and their perceptions of the importance of these competencies to their leadership role. To determine if a relationship exists this study was guided by three research questions including:

- What are the EI competencies identified as important for leadership by hospitalist medical directors?
- How do hospitalist medical directors rate their EI performance?
- How do self-reported EI competencies correlate to hospitalist medical directors' perceptions of their leadership role?

The Changing Landscape of Healthcare in the United States

Problem

Over the past century, reforms such as the institution of health insurance, the creation of Medicare and Medicaid, the increased use of technology, and improved

medications have aimed at improving the efficiency and effectiveness of healthcare in the United States. However, many of these initiatives have not led to substantive change. As a result, the United States healthcare system is viewed by many as broken (Kirchhemer, 2008; McGlynn, et al., 2003; Starfield, 2000). This conclusion was, partially, formulated by the history of healthcare in the United States.

History

As shown in Table 1, the history of healthcare in the United States demonstrates that reform has been a theme since the early 1900's. In addition, each decade has faced its own unique challenges (PBS, n.d.).

Table 1

History of Healthcare in the United States

Decade	Unique Challenge
1900s	Physicians were no longer expected to provide free services to all patients.
1910s	The American Association for Labor Legislation (AALL) organized the first national conference on "social insurance" and reformers argued for health insurance.
1920s	The higher cost of medical care was a new development, especially for the middle class. General Motors signed a contract with Metropolitan Life to insure 180,000 workers.
1930s	Blue Cross began offering private coverage for hospital care in dozens of states.
1940s	Prepaid group healthcare began because during World War II, wage and price controls were placed on American employers. To compete for workers, companies began offering health benefits which established an employer-based system. President Roosevelt asked Congress for an "economic bill of rights" which included the right to adequate medical care. President Truman offered a national health program plan that proposed a single system that would include all of American society.
1950s	At the start of the decade, national health care expenditures were 4.5% of the Gross National Product.
1960s	Over 700 insurance companies were selling health insurance and President Lyndon Johnson signed Medicare and Medicaid into law.

Table 1 continued

History of Healthcare in the United States

Decade	Unique Challenge
1970s	President Richard Nixon renamed prepaid group health care plans as health maintenance organizations (HMOs), with legislation that provided federal endorsement, certification, and assistance. Healthcare costs escalated rapidly, partially due to unexpectedly high Medicare expenditures, rapid economic inflation, expansion of hospital expenses and profits, and changes in medical care including greater use of technology, medications, and conservative approaches to treatment. American medicine was now seen as in crisis.
1980s	Under President Reagan, Medicare shifted to payment by diagnosis instead of by treatment. Private plans adopted the same approach. "Capitation" becomes more common. Capitation is a “method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount without regard to the actual number or nature of services provided to each patient” (“Capitation”, n.d.).
1990s	Health care costs rose double to the rate of inflation. Federal health care reform legislation failed to pass in the U.S. Congress. By the end of the decade there were 44 million Americans, 16% of the nation, with no health insurance at all.
2000s	Medicare was viewed by some as unsustainable under the present structure and needs to be "rescued". The changing demographics of the workplace led many to believe that the employer-based system of insurance could not last. Direct-to-consumer advertising for pharmaceuticals and medical devices was on the rise. In 2006 national health care expenditures were 15.3% of the Gross Domestic Product (World Health Organization, 2009).

(PBS, n.d.)

The result of this history was demonstrated when comparing expenditures on health and mortality statistics between the United States and a sample of other nations shown in Table 2.

Table 2

Expenditures on Health and Mortality

Country	Total expenditure on health as % of gross domestic product (2006)	Per capita total expenditure on health at average exchange rate (US$) (2006)	Life expectancy at birth both sexes (2007)	Infant mortality rate probability of dying by age 5 per 1000 live births both sexes (2007)
Australia	8.7	3,302	82	6
Canada	10.0	3,917	81	6
France	11.0	3,937	81	4
Germany	10.6	3,718	80	4
Japan	8.1	2,759	83	4
Netherlands	9.4	3,872	80	5
Sweden	9.2	3,973	81	3
United Kingdom	8.2	3,332	80	6
United States	15.3	6,719	78	8

(World Health Organization, 2009)

This information indicates that healthcare costs in the United States are greater than many other developed countries. It may also suggest that this increased cost does not translate to lower morbidity, higher life expectancy, or better quality of care. Finally, this information may also suggest that the United States healthcare system functions differently than other developed countries.

Characteristics

The history of healthcare in the United States has been both a catalyst and a result of several unique characteristics. These characteristics included the absence of a central governing agency, access to health care services that was selectively based on insurance coverage, and health care that was delivered under imperfect market conditions. Characteristics of imperfect market conditions include a lack of product and service

standardization, entry and exit barriers for new firms, and price controls (McConnell & Brue, 2008).

Other characteristics included third-party insurers acting as intermediaries between financing and delivery functions and the existence of multiple payers. In addition, the balance of power among various stakeholders prevented any single group from dominating the system. Finally, legal risks influenced practice behavior, the development of new technology created an automatic demand for its use, and quality was no longer accepted as an unachievable goal in the delivery of health care (Shi & Singh, 2008). These characteristics have also hastened the development of a powerful influence on the functioning of the United States Healthcare system, consumerism.

Consumerism

The United States health care system is influenced by consumerism. Consumerism is defined as, "an organized movement of citizens and government agencies to improve the rights and power of buyers in relation to sellers" (Armstrong & Kotler, 2009, p. 487). Kerfoot (1996) believed;

> health care consumers are demanding a much higher level of service quality and are insisting that we become more interpersonal in their care. Consequently, we have had to become much more concerned about patients' perception of care. We now place more emphasis on addressing this need and use sophisticated patient satisfaction tools to measure patient and family perceptions of care. (p. 59)

Consumers have driven the creation of publications that rank health care institutions and are utilized by the public for decision making (Taylor, 2006). For example, the periodical US News and World Report (n.d.) annually ranks the best hospitals in America. Since

2002, the Malcolm Baldrige National Quality Award has included health care organizations (Baldrige National Quality Program, n.d.). The National Quality Forum has focused on improving the quality of healthcare in the United States through, "setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs" (The National Quality Forum, 2009, para. 1). Finally, the Press-Ganey organization has been noted for the ranking, marketing, and development of excellent hospitals through the use of its measurement techniques, standards, and broad communication of these results in the marketplace (Press-Ganey, 2009).

Consumerism and patient autonomy, pricing pressures applied by insurance companies and governmental programs, increased regulatory oversight and marketplace competitiveness, and a focus on cost containment have, naturally, become challenges for health care leadership (Eiser, Eiser, & Palmer, 2006). The needs of this complex industry requires health care leaders, specifically physician leaders, to reexamine leadership paradigms and practices (Gerbarg, 2002).

The Changing Roles and Responsibilities of Physician Leaders

As the United States healthcare system gained complexity, the practices of physician leaders in this system may no longer be effective (Beckham, 1995; Lloyd & Lyons, 1995; Smith, 1990; Van Harrison, 2004). Physician leaders are being challenged to change, adapt and improve their approach to effectively lead their organizations (Lazarus, 1997; McAlearney, et al., 2005). Gerbarg (2002) suggested that, "Hospitals…were in short supply of experienced physician leaders and managers who

could help to combine the business needs and models with the realities of clinical practice" (p. 3). As a consequence, many physician leaders are not prepared for the current leadership demands of their roles (Kaplan & Feldman, 2008).

Physician Leadership Skills

Physicians assume leadership roles for a variety of reasons such as, having a passion for leadership, having a desire for new challenges and greater influence, or showing an interest in a career-change (Berger, 1999; Lloyd & Lyons, 1995). However, many physician leaders find that their leadership skills are ineffective because, often, their academic training and, specifically, graduate and medical school curriculum did not introduce them to leadership topics (Berwick & Nolan, 1998; Dressler, et al., 2006; Jaeger, 2003). Lloyd and Lyons (1995) provided common sense advice when stating, "an MD or DO degree alone will not serve as a management credential; innate skills must be bolstered by professional training and experience to create a true physician executive" (para. 13). Grossman (2000) suggested that physician leaders are ill prepared for their leadership roles when stating;

> Health care suffers from having medical doctors as managers. Doctors are very smart, used to finding the answers themselves. But, they're not necessarily smart around the soft side of people. They've gotten by on their intellect, tenacity, and analytical problem-solving. (p. 19)

Additionally, physician mentoring programs often expose younger physicians to controlling leadership styles that, while effective in times of crisis, create resistance to change and leadership oversight when applied to managing groups and individuals in

healthcare organizations (Burack, Irby, Carline, Root, & Larson, 1999; Prather & Jones, 2003).

Physicians often lack effective leadership skills because they, as medical students "are socialised into a tribe with distinctive beliefs and practices. It is an environment where 'real doctors get on with the job and only the weak weep or feel distressed'" (McMullen, 2002, p. 170). Physicians, in greater numbers, are seeking education, development, and training in leadership and business through seminars and education, such as advanced business degrees. To meet the leadership challenges of today's healthcare environment, a significant investment in physician leadership training must be made (Levey, Hill, & Greene, 2002).

Leadership Challenges: Shifting Perspectives

The leadership development of physicians could include shifting the physician's self-perception. Physician leaders can begin to think of themselves as executives who happen to be physicians rather than physicians who happen to be executives (Zaher, 1996). Physician leaders often operate in dual roles as both clinicians and administrators which presents challenges. For example, physicians work autonomously and independently while administrators work with teams, respond to feedback and objectives established by boards, and emphasize collaboration. Physicians operate with tangible and clear metrics for success while administrators address chronic ambiguity and extended time frames. Physicians operate reactively while administrators operate proactively. Physicians focus on the delivery of care on the front-line while administrators focus on the systemic process of healthcare delivery. Physicians are generally acknowledged for individual achievement while administrators are acknowledged for and focus on group

accomplishments (Gill & Lambert, 2004). What may be most challenging for physician leaders is balancing the delivery of care with meeting organizational objectives.

While physician leaders should develop and demonstrate effective leadership skills, health care organizations can also assist these leaders by addressing barriers that make leadership responsibilities unattractive to physicians (Mountford & Web, 2009). Mountford and Web submitted three potential barriers to clinical leadership. The first was physician skepticism regarding spending time on leadership rather than attending to patients. The second was disincentives such as lower salary scales for managers when compared to physician salary scales. Also, additional managerial responsibilities reduce the amount of time physicians can dedicate to private practice and research. Finally, the third barrier was the lack of training and support given to physicians who assume leadership roles. Often physician leaders are dropped into the leadership "deep end" and left to fend for themselves without organizational support.

Just as physicians and their employing organizations explore the creation of mutually beneficial and satisfying leadership roles, the characteristics of effective physician leaders has been widely researched (Adamson, Cant, & Atyeo, 2000; Gerbarg, 2002; Grebenschikoff, 1995; McKenna, Gartland, & Pugno, 2004; Peirce, 2000; Prather & Jones, 2003; Rossiter, Greene, & Kralewski, 2000; Zaher, 1996). Given the quantity of research, the list of competencies and skills of effective physician leaders was lengthy and, can be considered somewhat daunting. The leadership competencies included; organizational governance, financial management, human resources management, management of the patient care process, and informatics and information systems oversight. Also included were strategic thinking, change management, the training and

development of staff, effective communication, collaboration and team building, awareness of personal values, vision and mission, and fostering innovation. Prather and Jones (2003) suggested that effective physician leaders should demonstrate characteristics and skills including, project management, visioning, and systems thinking. Knowledge of human behavior, group performance and motivation provide critical support for performance measurement and counseling reflective of evidence based medical practice which integrated research based evidence and patient values when making medical care decisions (Torpy, Lynm, & Glass, 2009). Peirce (2000) stated that an effective physician leader would be one;

> one who others trust and have confidence in following because of that person's values, vision and capabilities, and expertise in handling unstable difficult situations, especially the capability of managing frustration, anxiety, conflict, and operating at the edge of chaos by balancing productivity with innovation. (p. 25)

In addition, successful physician leaders "will keep human suffering as the uppermost concern" (Peirce, 2000, p. 25). These characteristics led to the conclusion that effective physician leaders will need detailed knowledge of the variety of disciplines to make health care organizations work well.

Healthcare Leadership Model

To assist in developing healthcare leaders, The National Center for Healthcare Leadership (NCHL) (2005) created the Health Leadership Competence Model. This competency model was comprised of three categories. The first category was people, which included competencies such as human resource management, interpersonal understanding, professionalism, relationship building, self confidence, self development,

talent management, and team leadership. The second category was execution, which included competencies such as accountability, change leadership, collaboration, communication skills, impact and influence, information technology management, initiative, organizational awareness, performance measurement, process management and organizational design, and project management. The final category was transformation, which included competencies such as achievement orientation, analytical thinking, community orientation, financial skills, information seeking, innovative thinking, and strategic orientation. The NCHL suggested that the most effective physician leaders would be fluent in each of the three categories and have a strong understanding of leadership.

Leadership: An Elusive Construct

The exploration, study, and teaching of leadership continues to grow. Bass and Bass (2008) found that since mid-1999 over 55,172 publications on leadership were listed in the "Online Computer Library Center" (p. 6). The volume of material suggested that there is great interest in understanding and improving the practice of leadership.

Definitions of Leadership

Perhaps a reason for the high volume of material regarding leadership is the challenge of clearly defining leadership. DePree (1989) provided the following definition of a leader, "The first responsibility of a leader is to define reality. The last is to say thank you" (p. 11). DePree added to this definition several goals that leaders should aspire to including, "leaders should leave behind them assets and a legacy, leaders are obligated to provide and maintain momentum, leaders are responsible for effectiveness, leaders must take a role in developing, expressing, and defending civility and values" (pp. 13-21).

Gardner (1990) provided a more targeted definition of leadership, "Leadership is the process of persuasion or example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his or her followers" (p. 1). Drucker (2001) defined leadership as consisting of clearly defining and articulating a vision and direction, as a responsibility rather than a privilege and finally, that leadership was based on trust. These definitions demonstrate that there is no single definition of leadership. However, several common elements include, the ability to define and articulate a vision, set objectives, establish shared values, and motivate and focus followers.

Leadership Paradigms

While there is no widely agreed upon definition of leadership, Avery (2004) suggested a framework to assist in understanding leadership from a historical and methods of practice perspective. Avery believed that there are four major leadership paradigms, classical, transactional, visionary and organic. Each of these paradigms was distinguished by a time period when they were most prominently used and developed, a clear leadership and follower relationship, and a distinct viewpoint regarding how to determine and set a vision for an organization. Avery's model is shown in Table 3.

Table 3

Leadership Paradigms

Leadership Characteristic	Classical	Transactional	Visionary	Organic
Major era	Antiquity-1970s	1970s-mid-1980s	Mid-1980s-2000	Beyond 2000
Basis of Leadership	Leader dominance through respect and/or power to command and control	Interpersonal influence over and consideration of followers. Creating appropriate management environments	Emotion-leader inspires followers.	Mutual sense-making within the group. Leaders may emerge rather than be formally appointed.
Source of follower commitment	Fear or respect of leader. Obtaining rewards or avoiding punishment.	Negotiated rewards, agreements and expectations.	Sharing the vision; leader charisma may be involved; individualized consideration.	Buy in to the group's shared values and processes; self-determination.
Vision	Leader's vision is unnecessary for follower compliance.	Vision is not necessary, and may not ever be articulated.	Vision is central. Followers may contribute to leader's vision.	Vision emerges from the group; vision is a strong cultural element.

(Avery, 2004, p. 19)

What was important for the interpretation and practical application of Avery's model, was the recognition that while each of the leadership styles are shown during a set timeframe, each style should be at a leaders' disposal. In the correct situation, each of these approaches would be an appropriate leadership response. This theme of using the right leadership approach at the right time is consistent in much of the leadership research.

Farkas and Wetlaufer (1996) found "that in effective companies, CEOs do not simply adopt the leadership approach that suits their personalities but instead adopt the

approach that will best meet the needs of the organization and the business situation at hand" (p. 111). In addition, these authors identified five leadership approaches. The first was the strategic approach which was used by leaders who emphasize long-term strategy and were outward focused in an attempt to chart the organization's direction. The second approach was the human-assets approach which emphasized the development and growth of individuals in the organization. The third was the expertise approach which was incorporated by leaders who seek a distinct competitive advantage. The fourth approach was the box which rewarded "uniform, predictable behaviors" (p. 112). The final approach was titled the change approach. This approach was employed by leaders who defined their purpose as creating an environment of change. While these models provided increased clarity to the definition of leadership, as well as the importance of leadership flexibility, effective leadership behaviors were still, at best, intangible.

Leadership Theories and Approaches

Northouse (2010) articulated ten distinct leadership theories and approaches that outlined, with greater clarity, effective leadership behaviors. These theories and approaches included the trait approach, skills approach, style approach, situational approach, the contingency theory, path-goal theory, leader-member exchange theory, transformational leadership approach, authentic leadership approach, and team leadership approach. Each of these theories and approaches will be described below.

Trait Approach

The trait approach built upon the "Great Men" construct of the nineteenth and early twentieth centuries. This approach attempted to identify innate qualities and characteristics of great leaders and determine how these traits differ from followers.

However, the trait approach does not suggest that those who are "great men" come from upper classes and possess inherited leadership qualities (Avery, 2004). Rather, through the identification of their traits a leader gains awareness of their strengths and areas for improvement.

As cited by Northouse (2010), scholarship by authors such as Kirkpatrick and Locke (1991), Lord, DeVader, and Alliger (1986), Mann (1959), Stogdill (1948, 1974) and Zaccaro, Kemp, and Bader (2004) have contributed to the development of this theory. The traits possessed by effective leaders that were consistent across these scholars' research included: intelligence, self-confidence, determination, integrity, and sociability (Northouse). Since the trait approach identified a set of traits that successful leaders possess, individuals can complete trait assessments to determine their own leadership strengths and areas for improvement. By gaining an understanding one's strengths and weaknesses, "leaders can try to make changes in what they do or where they work to increase their traits' potential impact" (Northouse, p. 25).

Skills Approach

The skills approach was a leader-centered view of leadership that focused on skills and abilities. As cited in Northouse (2010), the skills approach was first presented by Katz (1955). Katz identified three critical leadership skills including, technical, human, and conceptual. These skills varied in importance and usage depending on the hierarchical level of the leader. The skills approach emphasized that both knowledge and abilities were important for effective leadership practice. In addition, the skills approach ushered in the viewpoint that leadership was a combination of both innate abilities and learning.

The skills approach was further developed by the U.S. Army and Department of Defense in a comprehensive study in the 1990's conducted by Mumford, Zaccaro, Harding, Jacobs, and Fleishman (2000). These authors proposed that there were three components to the skills approach including, individual attributes, competencies, and leadership outcomes. Individual attributes of the leader included, general and crystallized cognitive ability, motivation, and personality. These individual attributes were integrated with three competencies, problem-solving, social judgment and knowledge. If this integration was successful the leadership outcomes would be effective problem solving and improved performance. The skills approach demonstrated that leadership can be learned and developed. Critical components for leadership growth were career experiences and the development that occurs, on-the-job (McCall, Lombardo, & Morrison, 1988).

Style Approach

As cited by Northouse (2010), the style approach was initiated through research at the Ohio State University in the 1940s, the University of Michigan in the 1950s and 1960s, and research conducted by Blake and Mouton (1978) in the 1960s and 1970s. The style approach enhanced the study of leadership by focusing, "exclusively on what leaders do and how they act" (Northouse, p. 69) toward followers rather than focusing solely on the leader.

The three core style approach studies determined that leadership activity was based on two behaviors, task and relationship. Therefore, "The central purpose of the style approach is to explain how leaders combine these two kinds of behavior to influence subordinates in their efforts to reach a goal" (Northouse, 2010, p. 69). Based on these two

behaviors, Blake and Mouton (1978) developed leadership styles titled, Country-Club, Team, Middle-of-the-Road, Impoverished and Authority-Compliance Management. Each of these styles represented a unique approach to balance task and relationship behaviors.

The style approach was pragmatic because leaders could assess their own behavior on two dimensions, task and relationship. In addition, "The style approach works not by telling leaders how to behave, but by describing the major components of their behaviors" (Northouse, 2010, p. 77). By reflecting on their behaviors, leaders can determine areas of strength and improvement for their leadership acumen.

Situational Approach

As cited in Northouse (2010), the situational approach was based on Reddin's 3-D management theory (1967) and developed by Hersey and Blanchard (1969). This popular leadership construct focused on balancing supportive and directive behavior to meet the need of subordinates' "competence and commitment" (Northouse, p. 89). The leadership behaviors included: delegating, supporting, coaching and directing.

This approach was revised several times with Blanchard remaining a constant contributor. The situational approach was based on the need of leaders to balance two behaviors, supportive or relationship behaviors and directive or task behaviors. Leaders choose one of four styles, delegating, supporting, coaching and directing based on the developmental levels of followers. The followers' developmental levels were a combination of competence, ability to complete the task and commitment to accomplish a given task. It was the leader's task to determine the development levels of followers then to match their leadership style to these needs.

Blanchard, Zigarmi, and Zigarmi (1985) proposed the Situational Leadership behavior model in Table 4.

Table 4

Situational Leadership

(Low) Supportive Behavior (High)		
	High Supportive and Low Directive Behavior SUPPORTING	High Directive and High Supportive Behavior COACHING
	Low Supportive and Low Directive Behavior DELEGATING	High Directive and Low Supportive Behavior DIRECTING
	(Low) Directive Behavior (High)	

(Blanchard, Zigarmi, & Zigarmi, 1985, p. 47)

In addition, Blanchard, Zigarmi, and Zigarmi submitted the following, Table 5, as a guide to determine followers' needs.

Table 5

Followers' Needs

Development Level of Follower	Appropriate Leadership Style
Low Competence and High Commitment	Directing Structure, organize, teach, and supervise
Some to Low Competence and Low Commitment	Coaching Direct and support
Moderate to High Competence and Variable Commitment	Supporting Praise, listen, and facilitate
High Competence and High Commitment	Delegating Turn over responsibility for day-to-day decision-making

(Blanchard, Zigarmi, & Zigarmi, 1985, p. 56)

Blanchard, Zigarmi, and Zigarmi's (1985) model concluded that leaders with the ability to change approaches based on the needs of followers were the most effective.

Situational leadership was prescriptive in that it provided tangible behaviors for leaders to follow to improve their leadership acumen. This approach required leaders to focus and pay attention to the needs of followers and treat them equitably but not necessarily the same. Finally, it was assumed that followers will "move back and forth along the development continuum" (Northouse, 2010, p. 94), therefore leaders would need to be perceptive, flexible and fluent in a variety of leadership approaches.

Contingency Theory

The contingency theory, as cited by Northouse (2010), was initiated by Fiedler (1964). At the core of this theory was the understanding that "Effective leadership is *contingent* on matching a leader's style to the right settings" (Northouse, p. 111). In essence, effective leadership matches the leader with a situation where their skills can be best utilized. Northouse proposed that, "In short, contingency theory is concerned with *styles* and *situations*" (p. 111).

The contingency theory proposed that leadership styles were "task motivated or relationship motivated" (Northouse, 2010, p. 111). Given this foundation, situational variables were identified, "in terms of three factors; leader-member relations, task structure, and position power" (Northouse, p. 112). Leader-member relations consisted of the trust between leaders and followers. Task structure, "is the degree to which the requirements of a task are clear and spelled out" (Northouse, p. 112). Finally, position power was the leaders' ability to reward or punish. From these three factors leadership style was measured by the Least Preferred Coworker (LPC) scale. Northouse proposed

that “Leaders who score high on this scale are described as relationship motivated, and those who score low on the scale are identified as task motivated” (p. 112).

Unlike other leadership approaches that suggested that leaders demonstrate flexibility in styles, contingency theory prescribed that leaders be matched with situations where they will do well. Therefore, this theory has some predictive ability in that leaders can be assigned projects and roles based on their strengths and the needs of the situation.

Path-Goal Theory

According to Northouse (2010), the path-goal theory arose in the 1970’s. A foundation for this theory was the Porter-Lawler expectancy model of motivation (Avery, 2004) which suggested that followers are motivated by the expectation that their effort and performance will lead to outcomes they value. “The stated goal of this leadership theory is to enhance employee performance and employee satisfaction by focusing on employee motivation” (Northouse, p. 125). Path-goal theory suggested that leadership behavior should strive to achieve the “best fit” for followers needs and the characteristics of the tasks that followers were attempting to complete. This interaction can be seen in the Table 6 below.

Table 6

Path-Goal Theory

Leadership Behavior	Subordinate Characteristics	Task Characteristics
Directive – provides guidance and psychological structure	Dogmatic Authoritarian	Ambiguous Unclear Rules Complex
Supportive – provides nurturance	Unsatisfied Need affiliation Need human touch	Repetitive Unchallenging Mundane

Table 6 continued

Path-Goal Theory

Leadership Behavior	Subordinate Characteristics	Task Characteristics
Participative – provides involvement	Autonomous Need for control Need for clarity	Ambiguous Unclear Unstructured
Achievement Orientated – provides challenges	High expectations Need to excel	Ambiguous Challenging Complex

(Northouse, 2010, p. 131)

Leader-Member Exchange Theory (LMX)

As cited by Northouse (2010), the LMX was developed by Dansereau, Graen, and Haga (1975). This theory proposed that leaders focus on the one-to-one interaction, called the dyadic relationship, between themselves and followers. This focus will lead to an in-group, characterized by a strong connection with the leader, and an out-group, characterized by less compatibility with the leader (Northouse, p. 150).

As the LMX theory developed emphasis was placed on leadership-making, the ability to develop leaders. It was proposed that leaders should attempt to make followers feel part of the group, included, and be a partner in the relationship. This relationship development would go through phases labeled as "the stranger," "acquaintance" and "mature partnership." Each of these stages were distinguished by greater levels of trust and respect between leaders and followers. Essentially, leaders should assist followers to move from the out-group to become part of the in-group.

The LMX was a prescriptive approach that could facilitate tangible training and development opportunities for leaders. This approach challenged leaders to assess their assumptions toward relationships, networking, and relationship management. The perceptual challenge with LMX was the appearance of fairness and equity however. If

some followers were part of the "in-group" what does that mean for those followers in the "out-group?"

Transformational Leadership

The term transformational leadership was coined by Dowton (1973), as cited by Northouse (2010). This approach emphasized the, "charismatic and affective elements of leadership" (Northouse, p. 171) with a focus on intrinsic motivation and the development of followers. Transformational leadership, "is the process whereby a person engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower" (Northouse, p 172).

Transformational leadership is considered one endpoint of a leadership continuum that includes transactional, as the midpoint, and laissez-fair leadership as the opposite endpoint. Bass (1985), as cited in Northouse (2010), proposed that transformational leadership was effective for, "(a) raising followers' level of consciousness about the importance and value of specified and idealized goals, (b) getting followers to transcend their own self-interest for the sake of the team or organization, and (c) moving followers to address higher-level needs" (Northouse, p. 176). Other researchers that have provided perspectives on transformational leadership include Bennis and Nanus (1985), and Kouzes and Posner (1987).

Kouzes and Posner (1987) suggested that effective leaders demonstrated five specific behaviors. The first was to challenge the process. A leader's primary role was to challenge the status quo and create change. The second practice was to inspire a shared vision through recognizing and appealing to values that are held in common and articulating an important mission and direction. The third practice was to enable others to

act. Leaders empower others to act by sharing information and power with others and removing barriers so others could act. The fourth practice was to model the way. Effective leaders do what they say they will do consistently over time and the leader's behavior was consistent with espoused beliefs. The fifth and final practice was to encourage the heart. To encourage the heart, effective leaders recognize the contributions of others, provide rewards, celebrate, and motivate others to achieve. Kouzes and Posner (1993) confirmed these practices when they compiled the characteristics of admired leaders as articulated by followers. The top five characteristics were honesty, forward-looking, inspiring, competence, and fair-mindedness.

Greenleaf (2002) presented the concept of servant leadership which would support the transformational approach. A servant leader emphasized others' needs first. To determine these needs a servant leader listens and understands first, then articulates a direction and vision of the future. A servant leader accepts and empathizes. A servant leader was self-aware regarding values, beliefs, strengths, weaknesses, and their own leadership tendencies. A servant leader behaves in much the same manner as a "Level 5 Leader" (Collins, 2001).

Collins (2001) proposed that truly outstanding leaders behave in a manner that builds, "enduring greatness through a paradoxical combination of personal humility plus professional will" (p. 70). These types of leaders, "elevate companies from mediocrity to sustained excellence" (p. 68). Their behavior demonstrates humility, low ego, and a focus on putting the company first. In addition, these leaders set high expectations, were open to various inputs, and had unwavering resolve despite difficult challenges.

Transformational leadership was an inspiring approach because it suggested that leaders do and can make a tremendous difference to others and organizational performance. Leaders are seen as role models, moral direction setters, and nurturers of dreams and ambitions. Leaders, in essence, are a catalyst for transforming followers and organizations.

Authentic Leadership

Authentic leadership does not have a "single accepted definition" (Northouse, 2010, p. 206) as it, as a construct, is still developing. However, three viewpoints on a definition have been proposed including, intrapersonal, developmental, and interpersonal. The intrapersonal definition focuses on the leader's self-knowledge, regulation and concept gained through life experiences. The developmental definition focuses on the, "pattern of leader behavior that develops from and is grounded in the leader's positive psychological qualities and strong ethics" (Northouse, p. 207). Finally, the interpersonal definition focuses on relationships and leadership as a partnership between leaders and followers.

The development of authentic leadership theory has been split between two approaches. The first approach was a practical approach (George, 2003; Terry, 1993) which is prescriptive. This approach provides leaders with tools to determine core issues before taking action. The second approach was theoretical. In this approach, leaders should demonstrate "four components: self-awareness, internalized moral perspective, balanced processing, and relational transparency" (Northouse, 2010, p. 217).

Authentic leadership as a construct is still developing. However, the idea of a leader being authentic and "who they really are" is a foundation for leadership credibility

(Kouzes & Posner, 1993). In addition, the focus on self-awareness exhibited by authentic leaders is one of the foundations of EI.

Team Leadership

As cited in Northouse (2010), team leadership was an approach that has a long history of investigation, dating back to the 1920s. Team leadership was viewed as an oversight function with the intention of the leader doing what was necessary for the team to be effective. Northouse proposed that, "Effective leaders have the ability to determine what leadership interventions are needed, if any, to solve team problems." (p. 245).

Larson and LaFasto (1989) were key contributors to the development of the team leadership approach and determined that effective team leaders demonstrate "the following behaviors: keeps the team focused on the goal, maintains a collaborative climate, builds confidence among members, demonstrates technical competence, sets priorities and manages performance" (Northouse, 2010, p. 255). In addition, excellent teams were characterized by, clear, elevating goals, results-driven structure, competent team members, unified commitment, collaborative climate, standards of excellence, external support and recognition, and principled leadership (Northouse).

The team leadership approach is complex so practical application is difficult. However, "the model is useful in helping the leader make decisions: Should I act? If so, how should I do so?" (Northouse, 2010, p. 260). This leadership approach asks that leaders, "do whatever is necessary to help the group achieve effectiveness" (Northouse, p. 256).

Psychodynamic Theory

A consistent theme in the psychodynamic theory of leadership was the importance of personality which was defined as, "a consistent pattern of ways of thinking, feeling, and acting with regard to the environment, including other people" (Northouse, 2010, p. 271). This approach focused, in addition to personality, on the integration of personality with leadership, and the relationship between leaders and followers. The development of leaders occurred by improving the awareness of leaders and followers of their own personality and the implications of personality in the workplace. Zaleznik (1977) was a leading proponent of this approach.

The psychodynamic theory draws heavily from personality research. One research theme and practical tool for understanding personality is the Myers-Briggs Type Indicator (MBTI). The MBTI is a tool designed to implement the theories of C.G. Jung, a Swiss psychiatrist and is the most widely utilized personality preference instrument in the world. The assessment reflects an individual's preferences and does not measure abilities, likelihood of success or intelligence. The MBTI is a useful and practical tool for achieving an understanding of self and the differences of others (Myers, 1998).

This theory, while complex, provides an excellent example that leadership can be development through improved self-awareness which leads to improved self-management and leadership. The MBTI is an effective tool in addition to multi-rater assessments, such as a 360-degree assessment, for increasing a leader's awareness of the impact of their behavior (Goldsmith, 2005).

In addition to improved self-awareness, all of the theories and approaches identified promote leadership flexibility. This flexibility in leadership approach assists

leaders in adapting to changing circumstances and environments. In the healthcare industry, adaptability and managing change has become a critical success factor. One approach, the adoption of hospitalists had shown promise toward improving hospital operations.

Hospitalists: Responding to the Changing Landscape of Healthcare

The Hospital Environment

Similar to the earlier description of the healthcare industry, hospitals are also highly complex organizations. In this setting, skilled employees and multiple stakeholders, including patients interact in an, often, intense emotional environment. Hospitals have been described as:

> A collection of parts that must work together to achieve the goal of the hospital. People, policies, facilities, programs and other components must be connected in some fashion to operate both separately and together to fulfill a specified objective, such as ensuring quality patient care, providing an opportunity for teaching and research, being a leader for innovative patient care, or identifying and implementing significant cost reduction measures. (Dolny & Mahon, 2000, p. 47)

In addition, hospitals are, "poorly understood, extremely costly, and rife with inefficiency. Because of this complexity, there are no detailed models that capture the overall operation of these systems" (Kopach-Konard, et al., 2007). Hospitals are entities that reflect the earlier descriptions of complex health care environments and require those who work within this context to be comfortable with and manage ambiguity. A group that has succeeded in this environment are hospitalists.

The Hospitalist Specialty – Who Are They?

Healthcare organizations, such as hospitals, have looked for care models to manage complexity and improve system performance metrics such as length of stay, quality of care, and patient satisfaction. One model was the establishment of the hospitalist specialty. Wachter and Goldman (1996) first coined the term "hospitalist" as a physician who treats patients in a hospital setting rather than an outpatient setting. Hospitalists generally do not have their own private practices rather, they care for patients who are hospitalized and referred to them by primary care providers (PCP). Upon completing the needed medical procedures and discharge from the hospital, the patients will return to their PCP for follow-up care and health maintenance. Wachter (1999) further refined this definition by stating:

> A hospitalist is a physician who spends at least 25% of his or her professional time serving as the physician-of-record for inpatients, during which time he or she accepts 'hand-offs' of hospitalized patients from primary care providers, returning the patients to their primary care providers at the time of hospital discharge. (p. 339)

While this definition had become the benchmark for much of the research regarding hospitalists, the SHM defined hospitalists as, "Physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to hospital medicine" (Society of Hospital Medicine, 2009). Both of these definitions point to a physician generalist, who should be capable of treating a variety of patients. Some have suggested that hospitalists should be able to effectively treat, the elderly, the seriously and

terminally ill, psychiatric, surgical and patients with dermatological, ophthalmic, and gynecological problems (Benson, 2002; Geehr & Nelson, 2002; Kingston, 2005).

A review of the characteristics of hospitalists supports the concept of a physician generalist. The SHM (2008) reported that 82.3% of hospitalists identified their specialty as general internal medicine up from 75% in 2006 (Society of Hospital Medicine, 2006). Other identified specialties included general pediatrics, 6.5%, internal medicine subspecialty, 4.0%, family practice, 3.7%, internal medicine pediatrics, 3.1%, and pediatrics subspecialty, 0.4% (Society of Hospital Medicine, 2008).

The picture of a hospitalist was further refined when exploring the demographics of this specialty. The SHM (2008) reported that the average age of hospitalists was 41 years and the gender distribution was approximately 56% male, 44% female. This gender distribution was not consistent with hospitalists in leadership capacities however, where the breakdown for leaders was 80% male and 20% female. The number of years as a hospitalist was approximately 5 with hospitalist leaders having a longer tenure at 6.7 years (p. 17). Finally, SHM (2008) estimated 21,613 hospitalists were currently practicing in the United States (Society of Hospital Medicine, 2008) which confirmed a study in 1999 that projected the number of hospitalists needed in the United States to be between 10,000 to 30,000 (Lurie, Miller, Lindenauer, Wachter, & Sox, 1999).

The Rise of Hospitalists

The rapid growth of the hospitalist specialty was originally linked to financial pressures from rising practice costs, such as malpractice, coupled with lagging reimbursement rates, hospital capacity constraints, lower patient satisfaction, and growing interest in patient safety improvements (Bishop & Kathuria, 2008; Davis, et al.,

2000; Freed, 2004; Hardy, Levy, & Murphy, 2000; Hauer, & Wachter, 2001; Pham, Devers, Kuo, & Berenson, 2004; Wachter, 2004b). Hospitalists have proven to be an effective solution in three important areas of hospital performance from the list above; reduction in the length of stay, patient satisfaction, and improvement in the quality of care (Auerbach et al., 2002; Chaty, 1998; Diamond, Goldberg, & Janosky, 1998; Everett, Uddin, & Rudloff, 2007; Frank & Gonzalez, 2002; Greeno, 2006; Gregory, Baigelman, & Wilson, 2003; Hackner, et al., 2001; Harrison & Curran, 2009; Harrison & Ogniewski, 2004; Kulaga, et al., 2004; Laverty, 2003; Meltzer, et al., 2002; Milstein, 1999; Palmer, et al., 2001; Rifkin, Holmboe, Scherer, & Sierra, 2004; Terry, 2008a & 2008b; Vasilevskis, Knebel, Wachter, & Auerbach, 2007; Wachter, 2004b; Wachter, 2000;. Wachter & Goldman, 1999). For example, in a study conducted at the Park Nicollet Clinic in Minnesota, the implementation of a hospitalist system led to a 17% decrease in consultation requests and a decrease in length of stay of .64 days (Freese, 1999).

Another study reported that the "median length of stay decreased from 6.01 to 5.01 days. Median cost of care decreased from $4139 to $3552, and the 14-day readmission rate decreased from 9.9 to 4.64 readmissions per 100 admissions" (Diamond, Goldberg, & Janosky, 1998, p. 197). A two-year study by Auerbach (2002) found that a voluntary hospitalist service produced reductions in length of stay, .61 days shorter, and costs, $822 lower. Halpert, Pearson, LeWine, and McKean (2000) found that the;

> average length of stay was reduced by 0.3 days (P = .008), and total hospital charges were reduced an average of $426 per admission (P = .001). In-hospital mortality rates, percentage of patients discharged home directly, and 30-day readmission rates did not change significantly in the post-intervention period.

> Satisfaction among primary care physicians was high, with 90% of those answering a survey responding that they would recommend a similar program to other primary care groups. (p. 549)

As mentioned earlier, patient satisfaction also appears to improve or be equal to the care of PCP when hospitalists programs are adopted (Freese, 1999; Laverty, 2003; Vansaghi, Stites, Pingleton, Turner, & Hansen, 2008). For example, in a study conducted at the Park Nicollet Clinic in Minnesota it was concluded that;

> In a larger, multispecialty group practice in a competitive managed care market, we found that the implementation of a hospitalist system was associated with costs savings and no decrease (and, in fact, some improvement) in satisfaction among inpatients, outpatients, and physicians." (Freese, p. 353)

However, caution should be used when citing patient satisfaction as a benefit of a hospitalist program as more research has focused on reduction in length of stay and improved quality of care. Further research is needed to determine if improved patient satisfaction is a common result of hospitalist programs (Harrison & Curran, 2009).

Finally, a 2007 study determined that;

> 67 percent of CEOs said hospitalists affective the cost of care positively. CEOs cite the following as being enhanced by their hospitalist program (in order of positive impact): quality of care (88 percent), quality of physician/hospital relations (74 percent), referrals from primary care physicians (72 percent), cost of care (67 percent), patient satisfaction (66 percent), independent physicians' on-call coverage (60 percent) and attracting primary care physicians to the hospital's staff (59 percent). ("On educating", 2007, p. 74)

The results listed above appear to confirm that the hospitalist specialty is an effective method for navigating complex hospital settings and improving hospital performance metrics (Craig, et al., 1999; Wellikson, 2008).

These metrics have been achieved because hospitalists were aware of a broad range of hospital processes, they practice in the hospital, and they frequently interact with stakeholders who influence patient satisfaction and recovery. These processes and stakeholders included, nurse workload, patient volume, staffing, and protocols for hospital labs and ancillary hospital services. By the nature of their role, hospitalists proved to be effective because they work collaboratively and were available and accessible because they have an onsite presence (Pressel, Rappaport, & Watson, 2008; Whitcomb, 1998). In addition, "Hospitalists also help to develop and implement evidence-based protocols. Given the importance of technology, hospitalists' efforts in developing, and implementing computerized physician order entry systems are invaluable" (Wilson, 2006, p. 56).

While the financial return realized through the implementation of hospitalist programs appeared positive, the continued growth of the specialty is enhanced by other factors. Hospitalists are being used more frequently to care for patients with no doctor or patients who are not covered by insurance plans (Vasilevskis, et al., 2007). Vasilevskis, et al., also proposed that the highest potential for hospitalist growth would be in the areas of, "surgical co-management, institutional quality initiatives, quality reporting initiatives, efficiency initiatives and supervision of allied health care providers." (p. 6). Additionally, there was great promise in hospitalists serving in teaching roles because, "medical

students and residents considered hospitalists and general medicine attending to be more effective teachers than subspecialists" (Kripalani, et al., 2004, p. 8).

Finally, the broadening role of care provided by hospitalists and hospitalist programs has been attributed to increasing patient acuity because many of the medical conditions that, in the past, had been treated in an inpatient context are now being treated by outpatient providers (Schroeder, Showstack & Gerbert, 1986; Sehgal & Wachter, 2006). This increased acuity requires physicians to be well versed in a variety of care areas. Finally, Wellikson (2008) provided an appropriate summary of the impact of hospitalists when stating, "Hospitalists try to improve the way the hospital thinks about their entire patient population by improving the system and thereby improving quality and performance" (p. 34).

As hospital performance and quality has increased in visibility and importance because of the greater marketing of high performing hospitals, the hospitalist specialty was the fastest growing specialty in the history of modern medicine (Wachter, 2007). In 2006, just ten years after the creation of the specialty, it was estimated that 40% of United States hospitals employed hospitalists (Scalise, 2006). In some areas of the country notably California, the birthplace of the hospitalist specialty, approximately 59% of hospitals have hospitalists (Vasilevskis, et al., 2007).

However, researchers have cautioned that healthcare organizations critically evaluate the need and risks of adopting hospitalist programs (Alpers, 2001; Auerbach, et al., 2000; Brown, 1998; Lindenauer, et al., 2007; McDonald, 2001; McMahon, 2007; Plauth, Pantilat, Wachter, & Fenton, 2001; Sox, 1999; Srivastave, et al., 2005; Terry, 2008a; Vasilevskis, et al., 2007; Wachter & Goldman, 1999; Wachter & Pantilat, 2001;

Wachter, Whitcomb, & Nelson, 1999). The potential disadvantages of hospitalists included discontinuity of care caused by the "hand off" of patients from PCPs to hospitalists which may lead to lower patient satisfaction (Calzada, 2002; Lo, 2001; Wachter, et al., 1999; Weissler, 1999), and hospitalist burnout because of the intense clinical pace (Goldman, 1999; Hoff, Whitcomb, & Nelson, 2002; Schroeder & Shapiro, 1999). In addition, researchers expressed concern over the ability of academic medical training to properly prepare hospitalists for the wide variety of competencies that are needed to function effectively in this role (Schroeder & Shapiro).

Another area of concern was the ability to fund hospitalist programs (Vansaghi, et al., 2008; Wachter, 2001; Ward, et al., 2002). It is commonly held that hospitalist programs will not support themselves financially (David & Helmchen, 2007; Gregory, et al., 2003). Wachter, et al., (1999) reported that;

> The point to emphasize is that hospitalist programs generally will not be financially self-sustaining through their professional fees alone. If the programs succeed in reducing length of stay and hospital costs while maintaining or enhancing quality, they create tremendous value for the entity that holds the financial risk for hospital care. (p. 51)

The Need for and Development of Hospitalist Leadership

As the adoption of hospitalists has grown, the need for skilled leadership in hospitalist programs has also increased (Levey, et al., 2002; Saint & Flanders, 2004). Some hospitalist physicians assume the role of medical director of a hospitalist program. Similar to other physician leaders, these medical directors have spent years in school to learn the delivery of care and medicine however most have not been exposed, in their

academic experience, to any formal leadership, management, or business concepts. Meyer, Fletcher, and Parker (2004) suggested that, "the traditional biomedical underpinnings of medical and health science education ignore interpersonal and communication skills in favor of natural science knowledge and technological skills" (p. 226).

Regardless of the physician's training and education, as medical directors they are held accountable for leadership responsibilities by their healthcare organization (Blankenbaker, et al., 1999; Dressler, et al., 2006; Harrison & Ogniewski, 2004). Hospitalist medical directors are uniquely challenged because they interact with a variety of stakeholders including, patients, patients' families, PCPs, nurses, hospital administrators, consulting physicians, hospitalist physician colleagues, post-acute care facility representatives, and insurance organizations (Hauer, et al., 1999; Nelson, & Whitcomb, 2002; Skinner & Spurgeon, 2005). In addition, hospitalist medical directors are-at the forefront of where clinical care and the business of medicine intersect (Bellet, 2002; Rohr, 2006). Harrison and Ogniewski (2004) found that, "Hospitalist physicians must understand not only the clinical component of health delivery but also the business implication of their actions related to patient advocacy and stewardship of hospital resources" (p. 316). To collaborate effectively and build relationships with stakeholders and to blend the integration of clinical care with the business of medicine, there may be an increasing need for leadership that demonstrates a strong foundation in emotional intelligence (EI).

The Value of EI in Healthcare Leadership Practice

Emotional Intelligence

The term and concept of EI was popularized by Salovey and Mayer (1990) as well as by a series of books and articles by Goleman (1995, 1998a, 1998b, 2000, 2001a, 2001b, 2002, 2006). EI is the ability to recognize one's own emotions, sense emotional input from others, and react appropriately to that input (Noland, 2008). The concept of EI is tightly linked to IQ (Goleman, 1995) hence EI has also been called Emotional Quotient or EQ (Bar-on, 1988). For this research, EI was used. While the term and definition of EI gained popularity in and since the 1990s the roots of the concept can be traced much further.

> Aristotle provided insight on the intelligent use of emotions when stating;
>
> Thus we can experience fear, confidence, desire, anger, pity, and generally any kind of pleasure and pain either too much or too little, and in either case not properly. But to experience all of this at the right time, toward the right objects, toward the right people, for the right reason, and in the right manner—that is the median and the best course, the course that is a mark of virtue (Aristotle, 350 B.C.E./1962, p. 43)

If one fast-forwards from the time of Aristotle, the genesis of EI can be attributed to Thorndike (1920) who suggested there were multiple intelligences. An intelligence can be defined as, "the ability to solve problems or fashion products that are of consequence in a particular cultural setting or community" (Gardner, 1993, p. 15). Thorndike proposed an intelligence related to interpersonal interactions, a component of EI, called social

intelligence. Thorndike defined social intelligence as, "the ability to understand and manage men, and women, boys and girls—to act wisely in human relations" (p. 228).

Gardner (1993) reflected on multiple intelligences when stating, "But I made a deliberate decision to write about "multiple intelligence": "multiple" to stress an unknown number of separate human capacities, ranging from musical intelligence to the intelligence involved in understanding oneself" (pp. xi, xii). Gardner (1983) proposed seven intelligences including; linguistic, logical-mathematical, spatial, musical, bodily-kinesthetic, interpersonal and intrapersonal. The final two intelligences, interpersonal and intrapersonal, correspond closely to EI. Gardner (1993) defined interpersonal intelligence as "the ability to understand other people: what motivates them, how they work, how to work cooperatively with them" (p. 9). Intrapersonal intelligence was defined as "a capacity to form an accurate, veridical model of oneself and to be able to use that model to operate effectively in life" (p. 9). While Aristotle, Thorndike, and Gardner provided glimpses of EI, the construct was officially coined in 1985.

Payne (1985) introduced, in a doctoral dissertation, the term and construct of EI. Payne suggested that EI is how one relates to emotion, in particular, the emotions of fear, pain and desire. Payne submitted that emotional suppression is a characteristic of modern civilization, but believed that EI could be learned and developed over time which has also been supported by a number of other researchers (Caruso & Salovey, 2004; Goleman, 1998a; Slacki & Cartwright, 2003).

Salovey and Mayer (1990)

Currently, there are three major conceptual models of EI (Spielberger, 2004). The first was presented by Salovey and Mayer (1990). Salovey and Mayer defined EI as, "The

ability to monitor one's own and others' feelings, to discriminate among them, and to use this information to guide one's thinking and action" (p. 189). Essentially, EI was the ability to process emotional information. The authors further refined their definition to include reference to reasoning about emotions and using emotions to assist thinking (Caruso, Mayer, & Salovey, 2002; Mayer & Salovey, 1993; Salovey & Mayer, 1990). Salovey and Mayer (1997) believed EI was:

> the capacity to reason about emotions, and of emotions to enhance thinking. It includes the ability to accurately perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth. (p. 10)

Mayer, Salovey, and Caruso (2000) continued to develop the theory and eventually presented a four branch model of EI. The first branch, emotional perception and identification, "involves recognizing and inputting information from the emotional system. The second and third branches, emotional facilitation of thought and emotional understanding, involve the further processing of emotional information with an eye to problem solving" (p. 107). The fourth branch, "emotion management, concerns emotional self-management and the management of emotions in other people" (p. 107). The four branch model is represented in Table 7.

Table 7

Mayer, Salovey, Caruso, and Sitarenios Four Branch EI Model

Branch	Description of measure
Perceiving emotion	Ability to identify emotions in faces and pictures.
Facilitating thought with emotions	Ability to harness emotional information and directionality to enhance thinking.

Table 7 continued

Mayer, Salovey, Caruso, and Sitarenios Four Branch EI Model

Branch	Description of measure
Understanding emotion	Ability to comprehend emotional information about relationships, transitions from one emotion to another, linguistic information on emotions.
Managing emotions	Ability to manage emotions and emotional relationships for personal and interpersonal growth.

(Mayer, Salovey, Caruso, & Sitarenios, 2001)

Bar-on

The second significant conceptual model of EI was offered by Bar-on (1988). Bar-on (2006) proposed that, "Ultimately, being emotionally and socially intelligent means to effectively manage personal, social and environmental change by realistically and flexibly coping with the immediate situation, solving problems and making decisions" (p. 14). Bar-on (1988) proposed EI, called EQ in Bar-on's research, as a mix of personality traits or abilities. Bar-on's model (2000) included 15 sub-scales as shown in Table 8.

Table 8

EI Model: Bar-on

Sub-Scale	Definition
Self Regard (SR)	Ability to be aware of, understand, accept, and respect oneself
Emotional Self-Awareness (ES)	Ability to recognize and understand one's emotions
Assertiveness (AS)	Ability to express feelings, beliefs, and thoughts and to defend one's rights in a nondestructive manner
Independence (IN)	Ability to be self-directed and self-controlled in one's thinking and actions and to be free of emotional dependency
Self-Actualization (SA)	Ability to realize one's potential and to do what one wants to do, enjoys doing, and can do
Empathy (EM)	Ability to be aware of, understand, and appreciate feelings of others

Table 8 continued

EI Model: Bar-on

Sub-Scale	Definition
Social Responsibility (RE)	Ability to demonstrate oneself as cooperative, contributing and constructive member of one's social group
Interpersonal Relationships (IR)	Ability to establish and maintain mutually satisfying relationships that are characterized by emotional closeness, intimacy, and by giving and receiving affection
Stress Tolerance (ST)	Ability to withstand adverse events, stressful situations and strong emotions without "falling apart" by actively and positively coping with stress
Impulse Control (IC)	Ability to resist or delay an impulse, drive, or temptation to act, and to control one's emotions
Reality Testing (RT)	Ability to assess the correspondence between what is internally and subjectively experienced and what externally or objectively exists
Flexibility (FL)	Ability to adjust one's feelings, thoughts, and behavior to changing situations and conditions
Problem Solving (PS)	Ability to identify and define personal and social problems as well as to generate and implement potentially effective solutions
Optimism (OP)	Ability "to look at the brighter side of life" and to maintain a positive attitude, even in the face of adversity
Happiness (HA)	Ability to feel satisfied with one's life, to enjoy oneself and others, and to have fun and express positive emotions

(Bar-on, pp. 365-366)

Goleman

The third significant conceptual model of EI was developed and popularized through a series of books and articles by Goleman (1995, 1998a, 1998b, 2002, 2006). Goleman's model mixed abilities and personality traits. The model has become a cultural phenomenon because of wide commercial success. As cited by Sardo (2002), Goleman's Harvard Business Review article (1998a), became the most widely requested Harvard Business Review reprint in the last 40 years because of its value in understanding and

developing leadership practice. Goleman's early EI concept contained five dimensions and 25 competencies (Goleman, 1998a; 1998b) and is represented in Table 9.

Table 9

EI Model: Goldman

Self-Awareness—Knowing one's internal states, preferences, resources, and intuitions. The ability to recognize and understand your moods, emotions, and drives, as well as their effect on others • Emotional Awareness: Recognizing one's emotions and their effects • Accurate self-assessment: Knowing one's strengths and limits • Self-confidence: A strong sense of one's self-worth and capabilities
Self-Regulation—Managing one's internal states, impulses, and resources The ability to control or redirect disruptive impulses and moods The propensity to suspend judgment—to think before acting • Self-control: Keeping disruptive emotions and impulses in check. • Trustworthiness: Maintaining standards of honesty and integrity • Conscientiousness: Taking responsibility for personal performance • Adaptability: Flexibility in handling change • Innovation: Being comfortable with novel ideas, approaches, and new information
Motivation—emotional tendencies that guide or facilitate reaching goals A passion to work for reasons that go beyond money and status A propensity to pursue goals with energy and persistence • Achievement drive: Striving to improve or meet a new standard of excellence • Commitment: Aligning with the goals of the group or organization • Initiative: Readiness to act on opportunities • Optimism: Persistence in pursuing goals despite obstacles and setbacks
Empathy—Awareness of others' feelings, needs, and concerns The ability to understand the emotional makeup of other people Skill in treating people according to their emotional reactions • Understanding others: Sensing others' feelings and perspectives, and taking an active interest in their concerns • Developing others: Sensing others' development needs and bolstering their abilities • Service orientation: Anticipating, recognizing, and meeting customers' needs • Leveraging diversity: Cultivating opportunities through different kinds of people • Political awareness: Reading a group's emotional currents and power relationships

Table 9 continued

EI Model: Goldman

Social Skills—adeptness at inducing desirable responses in others Proficiency in managing relationships and building networks An ability to find common ground and build rapport • Influence: Wielding effective tactics for persuasion • Communication: Listening openly and sending convincing messages • Conflict management: Negotiating and resolving disagreements • Leadership: Inspiring and guiding individuals and groups • Change catalyst: Initiating or managing change • Building bonds: Nurturing instrumental relationships • Collaboration and cooperation: Working with others toward shared goals • Team capabilities: Creating group synergy in pursuing collective goals

(Goleman, 1998a; 1998b)

Goleman (2002) refined this model to include two domains and four competencies. The first domain was Personal Competence which related to how we manage ourselves. This domain included the competence of self-awareness which was the ability to recognize and assess one's own emotions and to have self-confidence in one's capabilities. The second competence of the Personal Competence domain was self-management which was the ability to control, demonstrate, adapt, and effectively use one's emotions.

The second domain was Social Competence which determined how one manages relationships. This domain included the competency of social awareness which was the ability to recognize and understand the emotions of others through the use of empathy. The second domain also included relationship management which was the ability to use emotional input in interactions with others regarding motivation, influence, change, teamwork and collaboration. This model became popular for numerous EI researchers that followed Goleman (Offermann, Bailey, Vasilopoulos, Seal, & Sass, 2004).

Goleman (2006) further refined the EI construct by distinguishing between emotional and social intelligence. Goleman proposed that earlier EI models which included social intelligence competencies did not accurately represent the complex interactions in human relationships. Table 10 details the components of Goleman's social intelligence.

Table 10

Goleman's Social Intelligence Model

Social Awareness—referred to a spectrum that runs from instantaneously sensing another's inner state, to understanding feelings and thoughts, to "getting" complicated social situations. In included: • Primal empathy: Feeling with others; sensing non-verbal emotional signals. • Attunement: Listening with full receptivity. • Empathic accuracy: Understanding another person's thoughts, feelings, and intentions. • Social cognition: Knowing how the social world works.
Social Facility—sensing how another feels, or knowing what they think or intend, does not guarantee fruitful interactions. Social facility builds on social awareness to allow smooth, effective interactions. The spectrum of social facility included: • Synchrony: Interacting smoothly at the nonverbal level. • Self-presentation: Presenting ourselves effectively. • Influence: Shaping the outcome of social interactions. • Concern: Caring about others' needs and acting accordingly.

(Goleman, 2006)

The three significant conceptual models of EI provided by Salovey and Mayer, Bar-on, and Goleman have served as the basis for many variations of EI. One variant was used for the survey instrument employed for this research study.

Theoretical Foundation of the Survey Instrument Used in this Research

The survey instrument adapted for this study was based on the EI theory proposed by Freedman (2007a). Freedman (2007b)defined EI as "the ability to integrate thinking and feeling to make optimal decisions" (p. 81). Freedman's (2007b) model of EI included

three pursuits; emotional literacy, emotional management, and empathy. At the core of the model was the belief that "there is wisdom in feelings" (p. 34).

The first pursuit of Freedman's model was Know Yourself which involved increasing self-awareness, recognizing patterns of behavior and feelings. This pursuit helped people understand their own thoughts, feelings, and actions. Within this pursuit are the competencies of enhancing emotional literacy and recognizing patterns (Freedman, 2007a).

The second pursuit was Choose Yourself which entailed self-management and self-direction. In this pursuit people followed their intentions and lived and led more consciously. Within this pursuit were the competencies of consequential thinking, navigating emotions, intrinsic motivation, and optimism (Freedman, 2007a).

The final pursuit was Give Yourself which aligned daily choices with a larger sense of purpose. In this pursuit people led more effectively, related meaningfully with others, and achieved their vision and mission (Freedman, 2007a; 2007b). In addition, this pursuit was realized through the use of empathy, "the ability to recognize and appropriately respond to other people's emotions" (Freedman, 2007a, p. 186) and principled decision making. Within this pursuit were the competencies of developing empathy and pursuing noble goals. The complete model is show in Table 11.

Table 11

EI Model: Freedman

Pursuit	Competency	Definition
Know Yourself: Increasing self-awareness, recognizing patterns, and identifying feelings lets you understand what "makes you tick" and is a first step in growth. Notice what you do	Enhance Emotional Literacy (EEL)	Accurately identifying and interpreting both simple and compound feelings.
	Recognize Patterns (RP)	Acknowledging frequently recurring reactions and behaviors.
Choose Yourself: Intentionality. Building self-management and self-direction allows you to consciously redirect your thoughts, feelings, and actions (vs. reacting unconsciously). Do what you mean	Apply consequential thinking (ACT)	Evaluating the costs and benefits of your choices.
	Navigate emotions (NE)	Assessing, harnessing, and transforming emotions as a strategic resource.
	Engage intrinsic motivation (EIM)	Gaining energy from personal values and commitments versus being driven by others
	Exercise optimism (EO)	Taking a proactive perspective of hope and possibility.
Give Yourself: Purpose. Aligning your daily choices with your values, combined with compassion, allows you to increase your wisdom and achieve your vision. Do it for a reason	Increase empathy (IE)	Recognizing and appropriately responding to others emotions
	Pursue noble goals (PNG)	Connecting your daily choices with your overarching sense of purpose

(Six Seconds, 2010)

As the above definitions demonstrated, EI is a multidimensional construct (Bechara, Tranel, & Damasio, 2000; Lam, & Kirby, 2002; McCallum & Piper, 2000; Rozell, Pettijohn, & Parker, 2002). However, all of the EI constructs reviewed contain

common elements of recognizing and understanding emotions, empathy, the ability to control emotions, and adapt interpersonally (Bar-on, 2006). These elements were believed to be linked to and support improved leadership performance (Rosete & Ciarrochi, 2005). The application of EI to leadership practice was explored in the next section.

The Business Case for EI

The study of EI as connected to leadership practice has focused on both the individual success of leaders as well as a leader's impact and influence on organizational performance. Both of these topics can be considered the "business case" for the benefits of EI as a leadership tool. In this section both the individual and organizational leadership impact of EI will be explored.

Leadership Success

The impact of ineffective leadership was studied by Dearborn (2002) who submitted that, "Poor leadership significantly impacts an organization's ability to maximize ROI in all of its endeavors" (p. 523) and continued;

> Whether one is formally assigned a leadership role, or surfaces as a leader in a given situation requiring leadership, key contributors are intuitive about the needs of others, recognize the nuances of a situation, and seamlessly respond to create positive outcomes. These are differentiating factors, the emotional intelligence smarts that change the landscaping of our thinking about developing leaders. (p. 524)

As Dearborn proposed EI has been linked to leadership effectiveness (Abraham, 2004; Bachman, Stein, Campbell, & Sitarenious, 2000; Carmeli, & Josman, 2006; Checkland,

2004; Cherniss, 2000; Dearborn, 2002; Hawkins & Dulewicz, 2007; Pearman, 2002; Williams, 2008) because emotions play an important role in determining professional behavior (Abraham, 2000; Kramer & Hess, 2002). Saarni (2000) proposed that "emotions are functional: they serve to goad us into action whereby we initiate, modify, maintain, or terminate our relationship to the particular circumstances we are engaged in" (p. 70). In addition, researchers have suggested that the capacity to perceive emotions and practice empathy is critical to leadership success (Abraham, 1999; Ashkanasy & Daus, 2002; Douglas, Frink, & Ferris, 2004; Rosete & Ciarrochi, 2005). One could use emotions in the workplace to create an effective organizational culture, improve decision making, support individuals, and enhance working relationships (Kramer & Hess; Pearman, 2002).

Boyatzis (1999) found in a study of the financial performance of leaders that, "both cognitive and emotional intelligence competencies predicted performance. Of course, it is also important to note that 93% (i.e., 13/14) of the competencies predicting performance were from the emotional intelligence clusters" (p. 130). The leaders who scored above the median on EI competencies delivered $1.2 million more profit than their peers. This increased success was supported by McClelland (1998) who found that executives selected based on EI competencies exceeded their goals by 15 to 20%. Those executives that did not have high EI competence under-performed by approximately 20 percent.

In a study conducted by Spencer and Spencer (as cited in Cherniss, 1999), sales agents hired using emotional intelligence competencies sold $91,370 more than those sales agents hired not using emotional intelligence competencies. In addition, those sales

agents who were selected using emotional intelligence competencies had 63% less turnover during the first year than those agents not selected using emotional intelligence competencies.

Ruderman, Hannum, Leslie, and Steed (2001) saw strong links between emotional intelligence and successful leadership practice through the increased use of participative management, putting people at ease, self-awareness, composure, building and mending relationships, doing whatever it takes, decisiveness, confronting problem employees and change management. Another study suggested that, "Emotionally intelligent individuals received greater merit increases and held higher company rank than their counterparts. They also received better peer and/or supervisor ratings of interpersonal facilitation and stress tolerance than their counterparts." (Lopes, Grewall, Kadis, Gall, & Salovey, 2006, p. 132). These leadership studies have led to the belief that EI could also be an effective tool for improving organizational performance.

Organizational Success

Studies have demonstrated a link between EI and organizational success (Boyatzis, 1999; Carmeli, et al., 2008; Dearborn, 2002; Goleman, 1998; Kelley & Caplan, 1993). Cherniss (2001) proposed that EI influenced organizational effectiveness in a number of areas including, employee recruitment and retention, development of talent, teamwork, employee commitment, morale, and health. In addition, EI was show to improve innovation, productivity, efficiency, sales, revenue, quality of service, customer loyalty, and client or student outcomes. Dearborn (2002) supported the belief that the use of greater emotional awareness and management led to work teams that exhibited better performance because of the improved ability to exchange information, problem solve and

make decisions, and engage in productive conflict management (Druskat & Wolff, 2001; Jordan & Troth, 2004).

It was suggested ("The 2003 HBR", 2003) that EI has become a fundamental leadership competence that enhances professional success;

> In hard times, the soft stuff often goes away. But emotional intelligence, it turns out, isn't so soft. If emotional obliviousness jeopardizes your ability to perform, fend off aggressors, or be compassionate in a crisis, no amount of attention to the bottom line will protect your career. Emotional intelligence isn't a luxury you can dispense with in tough times. It's a basic tool that, deployed with finesse, is key to professional success. (p. 95)

While this was a strong endorsement for the EI construct, EI is not without opposition and question which was addressed in the next section.

EI: Caution and Questioned

The research that supports EI as a successful leadership competency and ability is substantial and has been popularized in business journals. However, the construct has faced scrutiny (Becker, 2003; Mayer, & Cobb, 2000; Mayer & Salovey, 1997). For example, some view Goleman's (1998b, 2001a) claim that EI accounted for between 85 and 90% of the difference between star performers and average performers in senior leadership positions as an indication that EI, "promise(d) more than can be delivered" (Zeidner, Roberts, & Matthews, 2008, p. 74). Critics offered that EI tried to integrate everything but IQ and therefore fell short in terms of specificity and clarity as a construct (Hedlund & Sternberg, 2000). In addition, researchers proposed that there was little substantive data to support the claim that EI was more important than IQ (Mayer,

Salovey, & Caruso, 2000). Consequently, a more balanced approach has been proposed that considered IQ as also important in understanding emotional processes (Ciarrochi, Chan, & Caputi, 2000).

In addition, the multidimensional nature of EI has caused difficulty in distinguishing EI from other intelligences and personality traits (Davies, Stankov, & Roberts, 1998). Davies, Stankov, and Roberts conducted three studies of EI and concluded, “little remains of emotional intelligence that is unique and psychometrically sound. Thus, questionnaire measures are too closely related to “established” personality traits, whereas objective measures of emotional intelligence suffer from poor reliability” (p. 1013). Dulewicz, Young, and Dulewicz (2005) found that IQ, EI, or EQ as the authors used, and what they describe as managerial competencies (MQ) were correlated to overall job performance. The authors proposed that, "This implies that someone with high IQ, EQ and MQ is more likely to perform better in their job than someone with low results" (p. 80). However, this study demonstrated that EQ (36%) made a greater contribution to overall performance than IQ (27%) or MQ (16%).

The questions and caution regarding EI was an indication that EI is a developing construct. Cherniss (2001) admitted, "There is still much that is unclear about the nature of emotional intelligence, the way in which it should be measured, and its impact on individual performance and organizational effectiveness" (p. 9). Birks, McKendree, and Watt (2009) confirmed that, “EI research is still in its infancy, and further research is needed before we can fully understand the role that EI might play in moderating stress or other outcomes” (p. 7). Despite uncertainty, EI’s application as a leadership tool in a number of industries, including healthcare has grown.

EI in Healthcare

The investigation of EI in relation to healthcare was primarily conducted in the areas of patient care and medical education (Birks & Watt, 2007; Clarke, 2006; Humpel, et al., 2001; Kooker, Shoultz, & Codier 2007; Pau & Croucher, 2003; Wagner, Ginger, Grant, Gore, & Owens, 2002). EI has been shown to lead to higher patient satisfaction and improved clinical performance (Austin, Evans, Magnus, & O'Hanlon, 2007; Deshpande & Joseph, 2009; Fariselli, Freedman, Ghini, & Valentini, 2008; Freshwater & Stickley, 2004; Smith, et al., 2008; Wagner, et al., 2002). Through using EI, physicians and caregivers are able to recognize and use emotions to facilitate communication, decision-making, and information gathering. Akerjordet and Severinsson (2004) concluded, "EI integrates important personal and interpersonal skills, which can lead to flexibility in handling change and better quality of care in the future, creating a more humanistic, compassionate and healing environment within health care" (p. 170). Unfortunately, studies have stated that critical EI competencies of, “self-awareness, initiative, empathy, conflict management, integrity, team management and other professional behaviors are typically missing from the clinical evaluation checklist” (Smith, et al., 2008, p. 298). While high value was placed on EI competencies in a healthcare environment, it appeared that practicing and applying EI competencies in this environment was a challenge.

Of great concern, as discussed earlier, was that the training physicians undergo does not, often, include EI components. McMullen (2002) stated that, "Since emotional problems account for about 30% of general practice consultations, it is reasonable to expect that a doctor would learn about emotional intelligence during training" (p. 170).

Several studies have provided evidence that empathy, a key component of EI, actually declined in medical students during the course of their medical education and was considered difficult to develop (Lu, 1995; Newton, et al., 2000; Shapiro, Morrison, & Boker, 2004; Winefield, & Chur-Hansen, 2000). Boylan and Loughrey (2007) suggested that, "there is a growing awareness that medical educators need to develop the skills of emotional intelligence in themselves and in their students" (para. 1). This lack of training and education may be related to the coping mechanism in medicine of detaching from emotions. Lewis, Rees, Hudson, and Bleakley (2005) found that;

> Although it makes sense that an ability to recognize and manage emotion in oneself and others is an important skill for doctors, there is a tangible tension in medicine concerning the whole field of emotion in practice. Traditionally, detachment has been valued in medicine, reflecting a belief that emotions will somehow interfere with a doctor's ability to carry out his or her job. An argument is often made that doctors must maintain distance from patients in order to generate objectivity in diagnosis and treatment. (p. 341)

Empathy is most often demonstrated through the interpersonal communication between patient and physician (Hojat, et al., 2002). A study that investigated the impact a training program in interpersonal communication had on patient satisfaction indicated that patient satisfaction was higher and physician practice was improved because patients provide more information which led to more accurate diagnosis and efficient and effective treatments (Kramer, et al., 2004; Linney, 1995; Roter, et al., 1998). The ability to communicate effectively was important, not only in clinical settings but also in administrative settings.

The value of EI to healthcare administration has been investigated and described as, "fundamental for getting along in the workplace and is a primary leadership and managerial competency" (Freshman & Rubino, 2002, p. 1). Freshman and Rubino proposed the following EI model, Table 12, with examples of how EI competencies could be demonstrated in administrative roles within healthcare organizations;

Table 12

EI and Healthcare Administration

Component	Definition	Examples of Application
Self-awareness	Having a deep understanding of one's emotions, strengths, weaknesses, needs, and drives.	1. Confidently making decisions when budgets must be trimmed in medical areas. 2. Recognizing that the late night committee meetings were affecting your family relationships.
Self-regulation	A propensity for reflection, ability to adapt to changes, saying no to impulsive urges.	1. Know when to step away if having an argument with a provider. 2. Act to correct medical billing compliance issues rather than ignore them. 3. Accept responsibility over additional health care facilities.
Self-motivation	Driven to achieve, being passionate over profession, enjoying challenges	1. Set up a senior manager retreat to allow the best environment for planning. 2. Be optimistic even when census was low. 3. Embrace diverse populations of patients and employees.
Social awareness	Thoughtfully considering someone's feelings when acting.	1. Think of the family's perspective when involved in bioethical decisions. 2. Be compassionate when dealing with employees and their personal problems affecting their work. 3. Be patient-centered.

Table 12 continued

EI and Healthcare Administration

Component	Definition	Examples of Application
Social skills	Moving people in the direction you desire	1. Be able to negotiate a favorable managed care contract. 2. Have employees satisfied with their performance evaluation. 3. Use good listening skills when talking with governing board members.

(Freshman & Rubino, 2002, p. 6).

Although EI has been shown to be important in the delivery of excellent patient care and improved administration, much less research has been conducted on the links between EI and physician leaders (Epstein & Hundert, 2002; Kerfoot, 1996). There have been no studies, to this author's knowledge, that links hospitalist medical directors and the use of EI to their leadership approach.

EI and Leadership Style

The integration of EI and leadership style and approach was the topic of a number of investigations and Goleman and Boyatzis (2008) provided the following connection;

> leading effectively is, in other words, less about mastering situations—or even mastering social skill sets—than about developing a genuine interest in and talent for fostering positive feelings in the people whose cooperation and support you need. (p. 76)

This connection was based on the assumption that EI was critical to leadership effectiveness. In that spirit, Goleman (2001a) suggested six distinct EI-based leadership styles that are shown in Table 13.

Table 13

EI Based Leadership Styles

Leadership Style	EI Competencies	Impact on Climate	Objective	When Appropriate
Visionary	Self-Confidence, Empathy, Change Catalyst, Visionary Leadership	Most strongly positive	Mobilize others to follow a vision	When change required a new vision or when a clear direction was needed
Affiliative	Empathy, Building Bonds, Conflict Management	Highly positive	Create harmony	To heal rifts in a team or to motivate during stressful times
Democratic	Teamwork and Collaboration, Communication	Highly positive	Build commitment through participation	To build buy-in or consensus or to get valuable input from employees
Coaching	Developing Others, Empathy, Emotional Self-Awareness	Highly positive	Builds strengths for the future	To help an employee improve performance or develop long-term strengths
Coercive	Achievement Drive, Initiative, Emotional Self-Control	Strongly negative	Immediate compliance	In a crisis, to kick-start a turn around, or with problem employees
Pacesetting	Conscientiousness, Achievement Drive, Initiative	Highly negative	Perform tasks to a high standard	To get quick results from a highly motivated and competent team

(Goleman, 2001a, p. 42)

Goleman (cited in “Leading”, 2002) provided a summary of this model when stating;

> if you are a resonant leader, you tune in to your own values, priorities, sense of meaning, and goals—and you lead authentically from those, and you do it in a way that you tune in to other people's sense of values, priority, meaning, and goals. (p. 26)

Emotionally intelligent leaders will intentionally deploy the leadership style that will most resonate with the needs of followers.

The EI competencies that characterized the leadership styles Goleman (2001a) proposed were supported by other leadership theorists (Farkas & Wetlaufer, 1996; Goffee & Jones, 2000, 2007; Mintzberg, 1998). Mintzberg (1976) suggested that "a great deal of the manager's inputs are soft and speculative—impressions and feelings about other people, hearsay, gossip, and so on" (p. 54). Goffee and Jones (2000) highlighted several EI competencies in their description of inspirational leaders, "They selectively show their weaknesses, they rely heavily on intuition to gauge the appropriate timing and course of their actions, they manage employees with something we call empathy and they reveal their differences" (p. 64). Goffee and Jones (2007) also suggested that leaders be honest and sincere, keep stakeholders involved, help others learn from failure, and focus on interdependence. Farkas and Wetlaufer (1996) discovered five distinct leadership approaches including, strategic, human-assets, expertise, box and change. The human-assets approach contained EI competencies and focused on growing and developing people through the sharing of values, behaviors, and attitudes. The terms and functions suggested by these theorists as essential for effective leadership indicated a foundation of EI competencies would be highly valued.

Another EI competency that was identified by leadership thinkers as important for effective leadership performance was self-awareness (Drucker, 2005; Livingston, 2003). Livingston stated that;

> the high expectations of superior managers are based primarily on what they think about themselves—about their own ability to select, train, and motivate their subordinates. What managers believe about themselves subtly influences what they believe about their subordinates, what they expect from them, and how they treat them. (p. 102).

Goleman (1998a) submitted that, "Self-awareness is the first component of emotional intelligence – which makes sense when one considers that the Delphic oracle gave the advice to "know thyself" thousands of years ago" (p. 95). Leaders that understand themselves, their preferences, styles and approach, tend to lead intentionally and honestly.

Finally, a fair amount of research relates transformational leadership to EI (Collins, 2001; Gardner & Stough, 2002; Sosik & Megerian, 1999; Wang & Huang, 2009). Gardner and Stough found;

> Leaders who considered themselves as more transformational than transactional reported that they could identify their own feelings and emotional states and express those feelings to others; that they utilize emotional knowledge when solving problems; that they are able to understand the emotions of others in their workplace; that they could manage positive and negative emotions in themselves and others; and they could effectively control their emotional states. (p. 75).

Collins (2001) found that "The most powerfully transformative executives possess a paradoxical mixture of personal humility and professional will" (p. 67).

Conclusion

The challenges of the United States health care system have served as the catalyst for change in physician leadership practice and the development of new care models such as the hospitalist specialty. As the hospitalist specialty has grown so too has the need for effective hospitalist leaders. These leaders have recognized the need for practices and behaviors that focused on effective collaboration and relationship building and the integration of clinical care with the business of medicine. A potential leadership approach, EI, may be an effective tool for hospitalist leaders. Further research was needed to determine how hospitalist medical directors assess their performance on emotional intelligence (EI) competencies and their perceptions of the importance of these competencies to their leadership role.

CHAPTER III: METHODOLOGY

Introduction

The purpose of this study was to determine hospitalist medical directors' performance on emotional intelligence (EI) competencies and their perceptions of the importance of these competencies to their leadership role. Research regarding the affect of EI on physician leadership was limited therefore, this study was meant to explore if a relationship existed between EI competencies and the physician leaders' perception of their role. To determine if a relationship existed this researcher focused on three research questions including, what were the EI competencies identified as important for leadership by hospitalist medical directors, how did hospitalist medical directors rate their EI performance, and how did self-reported EI competencies correlate to hospitalist medical directors' perceptions of their leadership role. This chapter will describe the research methodology used for this study.

Research Design

The researcher conducted a quantitative analysis using a relational, correlation research methodology (Robson, 2002). The study was relational because the research questions, data collection methods, analysis techniques, and sampling strategies were determined prior to data collection (Gay, Mills, & Airasian, 2006: Robson). Correlation was employed because the research, "involve[d] collecting data to determine whether, and to what degree, a relationship exists between two or more quantifiable

variables" (Gay, et al., 2006, p. 191). The data used for comparison was collected from hospitalist medical directors.

Population

This study used purposive sampling and originally identified 169 hospitalist medical directors, leading programs of three or more hospitalist physicians working in two multistate, outsourced physician services organizations. The threshold of leading three or more hospitalist physicians was used based on team research from Katzenbach and Smith (2003) who stated, "Virtually all the teams we have met, read, heard about, or been members of have ranged between two and twenty-five people. The majority of them…have numbered less than ten" (p. 45). Once the survey was distributed to the two outsourced physician services organizations, another organization expressed interest in participating thus increasing the sample size to 178. The researcher received permission to conduct the research from all organizations, in both verbal form and when in receipt of email distribution lists, before surveying the participants.

The difference between the intended and actual sample size was attributed to both the addition of a third organization and variation in the email distribution lists. With regard to variation in the distribution lists, organization A had quoted 140 participants however the distribution list contained 109. Of this 109, 11 emails were duplicates, eight were bad addresses, and two participants asked to be removed thus bringing the total to 88. For organization B, the original 29 participant list was actually 23. Of this 23, all emails were valid with no duplication. Finally, organization C was made up of 67 participants. All emails were valid with no duplication. This population size was

determined to represent 39.5% of the total population of hospitalist medical directors working in outsourced physician services organizations.

The researcher used data previously collected by the Society of Hospitalist Medicine (SHM) to assist in determining the total population of hospitalist medical directors working in multistate, outsourced physician services organizations. This population identification allowed the sample size percentage to be determined. SHM data was used because, "The SHM survey is the only source of national data from a survey specifically designed for hospitalists" (SHM, 2008, p. 7). In addition, "SHM is the largest organization in the nation representing hospitalists and the practice of hospital medicine" (SHM, 2010). Using a five step process, shown in Table 14 and explained in greater detail below, the researcher determined that the sample size, 178, represented 39.5% of the total population of hospitalist medical directors leading hospitalist physician groups in multistate, outsourced physician services organizations.

Table 14

Sample Size Calculation

Step	Question	Result
1	What was the total population of hospitalists in the U.S.?	21,613
2	What percentage of hospitalists were leaders?	26%
3	How many hospitalist medical group (HMG) leaders were in the total population of U.S. hospitalists?	5,619
4	How many HMG leaders were employed in multistate, hospitalist-only groups or management companies?	450
5	What percentage of the total population does the sample represent?	39.5%

The five step process began by answering the question, "What was the total population of hospitalists in the U.S.?" The SHM determined that, "3242 hospitalists" represented, "approximately 15% of the nation's hospitalists" (SHM, 2008, p. 6). These

data led to the determination that there were approximately 21,613 hospitalists in the U.S. at the time of this study.

The second step was answering the question, "What percentage of hospitalists were leaders?" The SHM (2008) data determined that:

> Approximately 2000 Hospital Medicine Groups (HMGs) represent[ed] almost 7000 hospitalist members of SHM. To be included in the survey, the survey required that the database have a regular mailing address for the group leader, resulting in a target population of approximately 1800 HMG leaders. (p. 5)

Therefore, approximately 26% of the SHM (2008) membership was HMG leaders.

The third step was answering, "How many HMG leaders were in the total population of U.S. hospitalists?" Using the percentage calculated in step two, 26%, and the total population calculated in step one, 21,613, there were approximately 5,619 HMG leaders in the U.S. at the time of this study.

The fourth step answered the question, "How many HMG leaders were employed in multistate, hospitalist-only groups or management companies?" Data from SHM (2008) indicated that 8% of the survey population was, "employed by multistate hospitalist-only group or management company" (p. 9). Therefore, the researcher determined that approximately 450 hospitalist leaders worked in multistate hospitalist-only groups or management companies. The fifth and final step was to determine the percentage of the total population represented by the sample. Using the known sample size, 178, and the total population size of HMG leaders working in multi-state hospitalist-only groups or management companies, 450, this percentage was 39.5%. The participants identify by this sample were sent a survey to collect their perceptions of their

performance on EI competencies and their perceptions of the importance of these competencies to their leadership role.

Data Collection

The survey instrument adapted for this study was developed by Freedman and the organization, Six Seconds: The Emotional Intelligence Network (SEI) and was titled the SEI 360 Feedback International Edition (SEI 360) (Freedman, 2007b). The researcher obtained written permission (Appendix A) to adapt this survey. The SEI EI model included three pursuits, know yourself, give yourself, and choose yourself. These three pursuits were represented by eight competencies, enhance emotional literacy (EEL), recognize patterns (RP), apply consequential thinking (ACT), navigate emotions (NE), engage intrinsic motivation (EIM), exercise optimism (EO), increase empathy (IE), and pursue noble goals (PNG). The complete SEI EI model was shown in Table 15.

Table 15

EI Model: Freedman

Pursuit	Competency	Definition
Know Yourself Increasing self-awareness, recognizing patterns, and identifying feelings lets you understand what "makes you tick" and is a first step in growth. Notice what you do	Enhance Emotional Literacy (EEL)	Accurately identifying and interpreting both simple and compound feelings.
	Recognize Patterns (RP)	Acknowledging frequently recurring reactions and behaviors.

Table 15 continued

SEI EI Model

Choose Yourself Intentionality. Building self-management and self-direction allows you to consciously redirect your thoughts, feelings, and actions (vs. reacting unconsciously). Do what you mean	Apply consequential thinking (ACT)	Evaluating the costs and benefits of your choices.
	Navigate emotions (NE)	Assessing, harnessing, and transforming emotions as a strategic resource.
	Engage intrinsic motivation (EIM)	Gaining energy from personal values and commitments versus being driven by others
	Exercise optimism (EO)	Taking a proactive perspective of hope and possibility.
Give Yourself Purpose. Aligning your daily choices with your values, combined with compassion, allows you to increase your wisdom and achieve your vision. Do it for a reason	Increase empathy (IE)	Recognizing and appropriately responding to others emotions
	Pursue noble goals (PNG)	Connecting your daily choices with your overarching sense of purpose

(Six Seconds, 2010)

Adaptations made to the original SEI survey included the addition of a scale to assess importance of the EI competencies and the reduction in the number of questions about personal lifestyle. Participants were asked a total of 32 questions related to EI. In addition, the rating scale for these questions was adjusted to include a true center or neutral point so as not to skew the data toward a positive response. The original and adjusted scales are shown in Table 16. Finally, additional narrative was added to assist participants' understanding of the importance scale.

Table 16

Original and Adjusted Scales

Original Scale	Adjusted Scale
I disagree	Not important/Disagree
I disagree slightly	Unimportant/Disagree Slightly
I agree	Neutral/Neutral
I strongly agree	Important/Agree Slightly
I very strongly agree	Very important/Agree

Participants were also asked eight demographic questions (Appendix B) such as the number of years of experience as a hospitalist medical director, the size and location of the hospital, and the number of years as a physician. In addition, seven "hospitalist success factor" questions such as, "Since I have become a medical director length of stay at the hospital has been reduced", were included. The demographic and hospitalist success factor questions served as comparison variables for the EI competencies. In total the survey contained 47 questions and was administered via an internet-based survey system.

This method was chosen because a majority of the communication between the participants and their employing organization was conducted via the internet. A test of the survey instrument was performed in late, January, 2010 to ensure the technology performed as expected (Robson, 2002). Following the successful result of this test, the survey participants were contacted.

The hospitalist medical directors selected for participation were sent an introduction email cosigned by the researcher and a senior representative from each organization (Appendix C). The cosigned introduction was meant to increase survey response because the survey participants were more familiar with the senior

representative than the researcher (Robson, 2002). The email outlined the purpose of the study, time commitment, and procedures. In addition, the email highlighted that the data would be used in aggregate form only. Originally, a preferred email address was to be returned to the researcher before survey distribution. However, it was concluded that this additional communication step may have a negative impact on the response rate and was thus excluded (Robson). A weblink for the survey was included in the introductory email and the opening page of the survey served as informed consent (Appendix D). Once participants indicated their consent they were directed to the survey and were given three weeks to respond.

The first survey round was conducted from February 10, 2010 to March 3, 2010 with Organization A. The second survey round was conducted from March 31, 2010 to April 27, 2010 with Organization B. The final survey round was conducted from April 16, 2010 to May, 3, 2010 with Organization C. These time periods were determined based on when the researcher received the email distribution lists. After the initial invitation, bi-weekly reminders were sent to participants who had not completed the survey. Upon survey completion the participants were thanked for their time and contribution. Once the data were collected, analysis was conducted.

Analytical Methods

The analysis meant to determine the relationship between the hospitalist medical directors' self-perceptions of their leadership role, and the importance of and their performance on emotional intelligence competencies. The primary research questions, "What are the EI competencies identified as important for leadership by hospitalist medical directors?" and "How do hospitalist medical directors rate their EI

performance?" were evaluated using descriptive statistics for both the importance and performance responses for the 32 EI questions. The responses to the EI questions were collected through the use of a Likert-type scale as described earlier. Descriptive statistics are, "the numerical, graphical, and tabular techniques for organizing, analyzing, and presenting data" (Argyrous, 2009, p. 14). The descriptive statistics that were analyzed were the range, standard deviation, mean, and standard error of the mean.

The range is the difference between the lowest and highest score and demonstrates the dispersion of each data set. The standard deviation is, "the average distance each score is from the average" (Argyrous, 2009, p. 138) and is the most frequently used measure of variation because it, "includes every score in its calculation" (Gay, et al., 2006, p. 309). The mean is the sum of all scores divided by the total number of responses and is the most preferred measure of central tendency (Argyrous, 2009). Finally, the standard error of the mean, "tells us by how much we would expect our sample means to differ if we use other samples from the same population" (Gay, et al., 2006, p. 339). In addition to the Likert-scale rating for each EI item an "additional comment" area was provided. This area was intended to collect clarifying narrative that could provide additional context for the numerical ratings. The results of narrative input was compiled and reviewed.

The final primary research question, "How do self-reported EI competencies correlate to hospitalist medical directors' perceptions of their leadership role", required additional statistical analysis. The first analysis was to determine the reliability of the instrument. At the time of this research the SEI 360 Feedback International Edition did not have calculated factor analysis. The reliability of a previous version had been

reviewed and adjustments were made to the question wording (Lorenzo Fariselli, personal communication, May, 18, 2008). However, the updated instrument had not been assessed for reliability. Therefore, the researcher conducted a reliability analysis of the collected data using Cronbach's alpha because it, "is an index of reliability associated with the variation accounted for by the true score of the "underlying construct" (Santos, 1999, para. 7).

Upon completion of the reliability assessment, the researcher combined survey questions according to the EI competency they were intended to measure. This grouping was identified by the SEI organization and is proprietary. The researcher determined that comparing EI competencies to demographic and hospitalist success factors questions would generate greater value than a comparison of individual questions to the demographic and hospitalist success factor questions.

After grouping the questions, correlations were determined comparing the performance ratings for the EI competencies to hospitalist success factor questions. The hospitalist success factor questions were numbers 33 through 39 of the survey. The purpose of this statistical technique was to determine if a relationship existed between EI and self-reported leadership success (Gay, et al., 2006).

Finally, factorial analysis of variance, ANOVA, was employed to determine the effect of independent variables, (the demographic questions), on dependent variables, (performance ratings for the EI competencies) (Gay, et al., 2006). The demographic questions were represented in the survey by question numbers 40 through 47. The responses to questions, "number of years as a physician" and "number of years at your current organization" were re-coded from five choices, 0-5, 6-10, 11-15, and 20+ to three

choices, 0-5, 6-10, and 11+. This procedure was implemented so the scales for all questions regarding number of years reflected three choices. Question 41, "Number of inpatient beds in your hospital?" provided space for participants to contribute the exact number. These contributions were re-coded into categories to allow for ANOVA analysis. For the analysis, "1-100" beds was coded as a 1, "101-200" beds a 2, and "201+" beds a 3. Question 47, "Number of individuals that report directly to you?" also provided space for participants to contribute the exact number. These contributions were re-coded into categories to allow for ANOVA analysis. For the analysis, "0-5" was coded as a 1, "6-10" a 2, and "11+" a 3. In summary, using descriptive statistics, correlation, and ANOVA the researcher sought to determine hospitalist medical directors' performance on EI competencies and their perceptions of the importance of these competencies to their leadership roles. The limitations of this research were outlined below.

Limitations

Assessing EI

A limitation for this study related to the multidimensionality of the EI construct (Bechara, et al., 2000; Davies, et al., 1998; Lam, & Kirby, 2002; Mayer, Caruso, & Salovey, 2000; McCallum & Piper, 2000; Rozell, et al., 2002). Due to this multidimensionality accurately assessing an individual's or a group's EI presents a challenge. Cherniss (2001) admitted, "There is still much that is unclear about the nature of emotional intelligence, the way in which it should be measured, and its impact on individual performance and organizational effectiveness" (p. 9). Becker (2003) supported this conclusion and proposed that EI, "has proven resistant to adequate measurement" (p.

193). Some authors have proposed that a standard definition be established and, based on this definition, standardized measures be developed (Davies, et al., 1998; Law, Wong, & Song, 2004). While these suggestions require caution, given the continued development of the EI construct, "one should anticipate the body of reliability and validity evidence to be growing with each new study" (Gowing, 2001, p. 131). To limit the challenge of multidimensionality, the researcher chose a survey instrument that was founded on an approach and theory that was developed in 1997 (Freedman, 2007b). In addition, this theory has been widely adapted to multiple industries (Freedman, 2007a). However, another challenge was faced because the participants were self-reporting.

Self Reporting

This study sought to determine how hospitalist medical directors assess their performance on EI competencies and their perceptions of the importance of these competencies to their leadership role. This approach was a potential limitation because self-report survey designs could be subject to respondent bias. Respondents, "may intentionally misrepresent the facts in order to present a more favorable impression" (Leedy & Ormrod, 2005, p. 184). Essentially, the respondents may provide answers that the researcher wants to hear (Joseph, Berry, & Deshpande, 2009; Robson, 2002). This bias can impact the validity of EI assessments.

Regarding EI self assessments, Roberts, Zeidner, and Matthews (2001) submitted that when exploring EI, "Self-perceptions may not be particularly accurate or even available to conscious interpretation, being vulnerable to the entire gamut of response sets and social desirability factors afflicting self-report measures, as well as deception and impression management" (p. 200). Other researchers have concluded that when

assessing emotional constructs a multi-method approach may be best (Dawda & Hart, 2000). Due to time constraints this researcher chose to use a quantitative assessment despite the limitations of this approach. In addition, to limit self-report bias the researcher intentionally used the opening of the survey as the informed consent. Through a thorough explanation of the research, procedures, benefits, and potential risks the researcher believed that participants would be comfortable thus respond honestly (Gay, et al., 2006). Finally, the confidentiality of the participants' responses was also stressed throughout all communication between the 178 hospitalist medical directors that participated in this survey and the researcher.

Sample

In total, 178 hospitalist medical directors, managing three or more hospitalist physicians, working in multistate, outsourced physician services organizations were invited to participate in this survey. This sample size represented 39.5% of the total population of hospitalist medical directors working in multistate, outsources physician services organizations. As with any quantitative survey, "the larger the sample, the better" (Leedy & Ormrod, 2005, p. 207). However, since this was a correlation study the sample size was representative because, "at least 30 participants are needed to establish the existence or nonexistence of a relationship" (Gay, et al., 2006, p. 110).

An additional limitation of this sample was the use of hospitalist medical directors from outsourced physician services organizations. With any research that focuses on a specific population, the ability to generalize the research findings to other populations may be challenging (Gay, et al., 2006). In essence, this specific population may not be

representative of all hospitalist medical directors and certainly may not be representative of all physician leaders.

Survey Limitations

In addition to sample size concerns, the reliability of the survey instrument was questionable. The Cronbach's alphas for the original SEI 360 Feedback International Edition were shown in Table 17.

Table 17

SEI 360 Feedback International Edition Cronbach's Alpha

Pursuit	Competency	Cronbach's Alpha
Know Yourself	EEL	.766
	RP	.523
Choose Yourself	ACT	.507
	NE	.739
	EIM	.608
	EO	.620
Give Yourself	IE	.634
	PNG	.657

(Six Seconds, proprietary material)

It has been suggested that Cronbach's alpha of, ".70 or higher [were] considered "acceptable" in most social science research situations" however, lower scores, such as .60, have sometimes been considered acceptable (Garson, 2010; UCLA, 2010). Given these reliability statistics the assessment was revised. However, the reliability of the revised instrument had not been calculated at the time of this study.

To address the reliability of the instrument, the researcher calculated the Cronbach's alpha for the collected data. This calculation was shown in Table 18.

Table 18

Cronbach's Alpha Calculation

Pursuit	Competency	Cronbach's Alpha
Know Yourself	EEL	.761
	RP	.712
Choose Yourself	ACT	.687
	NE	.766
	EIM	.614
	EO	.635
Give Yourself	IE	.628
	PNG	.418

Since several of these Cronbach's alphas are below the .70 level, the researcher explored different combinations of questions to determine if higher Cronbach's alphas could be reached which would indicate higher reliability (Garson, 2010; UCLA, 2010). For example, in this research, by removing one item from the ACT competency the Cronbach's alpha increased from .687 to .721. For the competency EIM by removing two items the statistic increased from .614 to .653. Therefore, the revised ACT and EIM competencies were used for further calculations in this study.

For the competency PNG the highest Cronbach's alpha statistic determined through various combinations of items was .507. For this competency the researcher then calculated correlations and found that no items correlated above a moderate level, .450 ($p<.01$ or $p<.05$). This result could be related to the multidimensionality of the EI construct. Therefore, the researcher decided not to include PNG in further research because the measure did not represent the variable, thus the resulting calculations would not accurately represent the degree of the relationship (Gay, et al., 2006) and compromise the findings that were discussed in the following chapter.

Conclusion

The purpose of this chapter was to describe the research methodology used in this study as well as to introduce the potential limitations of this methodology. The statistical techniques used were meant to explore if a relationship existed between EI competencies and the physician leaders' perceptions of their leadership role. The next chapter will present the results of the data collection and the implications of these findings.

CHAPTER IV: FINDING AND CONCLUSIONS

Introduction

The previous chapter outlined the methodology used in this research and how each research question was explored. This chapter will describe the results of the data collection and analysis. Included in this chapter will be the findings, conclusions, implications, and recommendations of this study.

This study intended to explore hospitalist medical directors' performance on EI competencies and their perceptions of the importance of these competencies to their leadership role. To determine if a relationship existed this study was guided by three research questions including:

- What are the EI competencies identified as important for leadership by hospitalist medical directors?
- How do hospitalist medical directors rate their EI performance?
- How do self-reported EI competencies correlate to hospitalist medical directors' perceptions of their leadership role?

Findings

Response Rate

In the previous chapter a description of the sample size was presented. In total, 178 hospitalist medical directors, managing three or more hospitalist physicians, working for multistate, outsourced physician services organizations were invited to participate in

this survey. This sample size represented 39.5% of the total population of hospitalist medical directors working for multistate, outsourced physician services organizations. From this sample, 59 responses were collected for a response rate of 33.1%. As with any quantitative survey, "the larger the sample, the better" (Leedy & Ormrod, 2005, p. 207). However, since this was a correlation study the response rate was representative because, "at least 30 participants are needed to establish the existence or nonexistence of a relationship" (Gay, et al., 2006, p. 110). The survey participants responded to several demographic questions outlined below.

Population Demographics

The demographic questions in this study served as independent variables for comparison to the EI competencies. The rating scales used for the demographic questions varied. The question regarding hospital location used a Likert-type scale and numbers were assigned to the responses for coding and analysis. The choice of "urban" received a 1, "suburban" received a 2, and "rural' received a 3. The demographic questions also included the number of inpatient beds in the participant's hospital and number of individuals who reported directly to the participant. The question allowed respondents to input the exact number of beds for their institution and the number of individuals who reported directly to them. The responses were transformed into categories to allow for coding and analysis. The responses regarding the number of inpatient beds was adjusted to reflect three categories including, "1-100" which was coded as a 1, "101-200" coded as a 2, and "201+" coded as a 3. The responses regarding the number of individuals who report directly to the participant was adjusted to reflect three categories including, "0-5" which was coded as a 1, "6-10" coded as a 2, and "11+" coded as a 3.

Several demographic questions were meant to determine the number of years the survey participants had spent in a variety of roles. These roles included number of years as a physician, as a hospitalist, at their current organization, and in their current leadership position. A Likert-type scale was used to measure these responses and numbers were assigned for coding and analysis. The Likert-type scale for, "number of years as a physician", "number of years at your current organization", and "number of individuals that report directly to you" were adjusted from five choices, 0-5, 6-10, 11-15, 16-20, and 20+ to reflect three choices, 0-5, 6-10, and 11+. This was done so the scale for all questions regarding number of years was consistent and reflected three choices. The choices of "0-5" years received a 1, "6-10" years received a 2, and "11+" years received a 3. Finally, the question, "was your current leadership position appointed or voluntary" used a Likert-type scale and, again, numbers were assigned for coding and analysis. The choice of "appointed" received a 1 and "voluntary" received a 2.

For the demographic questions, questions 40 through 47, frequencies were calculated and analyzed because they report, for each value of a variable, the number of times a particular score was represented (Argyrous, 2009). Appendix E contains the frequency tables for the demographic questions. The results included:

- Question 40, hospital location, "urban" was chosen 12 times (21.4%), "suburban" 31 times (55.4%), and "rural" 13 times (23.2%). There were three non-responses.
- Question 41, number of inpatient beds in the hospital, "1-100" beds was chosen 11 times (20.0%), "101-200" beds 23 times (41.8%), and "201+" beds 21 times (38.2%). There were four non-responses..

- Question 42, number of years as a physician, “0-5” years was chosen 10 times (17.9%), “6-10” years 12 times (21.4%), and “11+” years 34 times (60.7%). There were three non-responses.
- Question 43, number of years as a hospitalist, “0-5” years was chosen 32 times (57.1%), “6-10” years 15 times (26.8%), and “11+” years 9 times (16.1%). There were three non-responses.
- Question 44, number of years at your current organization, “0-5” years was chosen 36 times (64.3%), “6-10” years 13 times (23.2%), and “11+” years seven times (12.5%). There were three non-responses.
- Question 45, number of years in your current leadership position, “0-5” years was chosen 47 times (83.9%), “6-10” years 8 times (14.3%) and “11+” years one time (1.8%). There were three non-responses.
- Question 46, was your current leadership position appointed or voluntary, “appointed” was chosen 38 times (67.9%) and “voluntary” 18 times (32.1%). Again, there were three non-responses.
- Question 47, number of individuals that report directly to you, “1-5” individuals was chosen 20 times (36.4%), “6-10” individuals 21 times (38.2%), and “11+” individuals 14 times (25.5%). There were four non-responses.

For the two questions that allowed respondents to enter exact numbers, questions 41 and 47, an average was also determined. Regarding the number of hospital beds, survey participants practiced in hospitals with approximately 200 beds (201.11). The average number of individuals that reported directly to the participants was

approximately 10 (10.49). Again, for both of these questions there were four non-responses.

In summary, the majority of the respondents worked in 100-200 bed suburban hospitals. A majority of respondents indicated that they had been physicians for over 11 years and had been with their current organization for less than five years. In addition, a majority of respondents indicated that they had been in an appointed hospitalist leadership role for less than five years which also corresponds to their length of tenure as a hospitalist. Finally, respondents indicated that most supervised between six and 10 hospitalist physicians. In addition to these demographic questions a number of questions were asked to determine whether, as leaders, respondents had influenced programmatic success since becoming medical directors.

Hospitalist Program Success

The hospitalist success factor questions in this study also served as independent variables for comparison to the EI competencies. These questions used Likert-type scales and numbers were assigned to the responses for coding and analysis. The choice of "disagree" received a 1, "disagree slightly" received a 2, "neutral" received a 3, "agree slightly" received a 4, and "agree" received a 5.

Descriptive statistics were used to assess the importance of EI to the participants' leadership. As outlined in chapter 3, descriptive statistics are the numerical and tabular methods for organizing, separating, and delivering data (Argyrous, 2009). The descriptive statistics that were analyzed in Table 19 were the range, mean, standard error of the mean, and standard deviation. When the range is small the scores are close together and when the range is large the scores demonstrate greater variation. The mean is the average

score from the data set. A small standard error of the mean will indicate a small sampling error. Finally, the standard deviation will indicate the spread in the scores, therefore a small standard deviation will mean that the scores are close together and large standard deviation will indicate that the scores are further apart (Gay, et al., 2006).

Table 19

Descriptive Statistics for Hospitalist Success Factors Ordered by Question Number

Since I have become a medical director…	N	Range	Mean	Std. Error	Std. Deviation
I make decisions that lead to positive results	57	2	4.75	.063	.474
Length of stay at the hospital has been reduced	57	4	4.19	.129	.972
Quality of care indicators have improved	56	2	4.63	.083	.620
Cost of hospitalization has been reduced	56	4	4.02	.141	1.053
Patient satisfaction scores have improved	55	4	4.27	.133	.990
My time spent on direct patient care is appropriate	54	3	4.30	.144	1.057
My time spent on administration (i.e., budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate	55	4	3.55	.179	1.331
Valid *N*	54				

Table 19 shows that 54 participants had a valid response for the hospitalist success factor questions. This valid *N* is a determination of the total number of participants who answer all of the hospitalist success factor questions. The range of scores for each item varied from 2 to 4. The highest rated item was "I make decisions that lead to positive results", with a mean of 4.75, while the lowest rated item was, "My time spent on administration (i.e., budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate", with a mean of 3.55. The remaining six items had a mean higher than "agree slightly." The item with the highest standard error of

the mean and standard deviation was, “My time spent on administration (i.e., budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate”, with a standard error of .179 and a standard deviation of 1.333. The item with the lowest standard error of the mean and standard deviation was, “I make decisions that lead to positive results”, with a standard error of .063 and a standard deviation of .474. As mentioned earlier, these hospitalist success factor questions were used as independent variables for comparison to EI competencies which will be discussed in the next two sections.

EI Importance

The first research question in this study was, “What are the EI competencies identified as important for leadership by hospitalist medical directors?” This question sought to elicit how important the leader felt an EI competency was to their leadership role. A Likert-type scale was used in the questionnaire to measure the importance of the 32 EI items. Numbers were assigned to the responses for coding and analysis. The choice of “not important” received a 1, “unimportant” received a 2, “neutral” received a 3, “important” received a 4, and “very important” received a 5.

As with the hospitalist success factor questions, descriptive statistics were employed to explore the level of importance participants’ believed EI items to be for their leadership practice and approach. Table 20 contains the descriptive statistics that were reviewed by item. The statistics included the range, mean, standard error of the mean, and standard deviation. In addition, a review of the skewness and kurtosis statistics indicated that the data was within acceptable ranges. For skewness the acceptable range is between

plus and minus two and for kurtosis the acceptable range is between plus and minus seven (Curran, West, & Finch, 1996).

Table 20

Descriptive Statistics for Importance Ordered by Item Number

	N	Range	Mean	Std. Error	Std. Deviation
I notice others feelings	59	1	4.54	.065	.502
I use a wide variety of feeling words	59	2	3.95	.089	.680
I discuss the emotional impact of decisions	59	3	4.07	.093	.716
I make decisions based on important values	58	1	4.72	.059	.451
I accurately describe my own behavior	59	2	4.29	.080	.617
I am proactive take action without having to be pushed by others	59	2	4.59	.073	.561
I take responsibility for solving problems instead of blaming	59	1	4.73	.058	.448
I see the best in situations	59	2	4.25	.098	.756
I manage my reactions skillfully	59	3	4.47	.081	.626
I am aware of my reactions	59	2	4.58	.073	.563
I talk about the long term vision	59	2	4.54	.078	.597
I set goals that energize me	59	3	4.44	.091	.702
I express emotions appropriately	59	3	4.37	.093	.717
I genuinely care about people	59	1	4.83	.049	.378
I am independent	59	2	4.47	.095	.728
I inspire others with my passion and commitment	59	2	4.56	.081	.623
I am able to talk about what makes me anxious	59	4	3.88	.135	1.035
I accurately explain why someone feels a particular way	59	3	4.03	.108	.830
I adjust easily to new situations	59	2	4.47	.081	.626
I consider the consequences of my behavior on others	58	3	4.60	.078	.591
I am able to explain my feelings	58	4	4.17	.110	.841
I recognize the hot buttons that provoke me	59	3	4.36	.096	.737
I reflect before jumping to decisions	58	2	4.60	.078	.591
I manage my emotions effectively even in difficult situations	58	2	4.60	.074	.560
I think of solutions even in challenging situations	59	2	4.69	.065	.500

Table 20 continued

Descriptive Statistics for Importance Ordered by Item Number

	N	Range	Mean	Std. Error	Std. Deviation
I motivate myself	59	2	4.68	.066	.507
I include others feelings when making decisions	59	2	4.51	.082	.626
I appropriately communicate about emotions with others	58	3	4.00	.107	.816
I have integrity	58	1	4.90	.040	.307
I have an intuitive understanding of others	59	2	4.37	.090	.692
I encourage others to be helpful	59	2	4.59	.077	.591
I am truly interested in what others say	59	3	4.58	.088	.675
Valid *N*	55				

Table 20 shows that 55 participants had a valid response for the items concerning the importance of the EI item to their leadership practice and approach. This valid *N* is a determination of the total number of participants who answer all of the EI questions regarding importance. The range for each item varied from 1 to 4. Further analysis was conducted on the mean, standard error of the mean, and standard deviation.

With regard to the means, the highest rated item was “I have integrity”, with a mean of 4.90 as shown in Table 21. The remaining top five included, “I genuinely care about people”, mean of 4.83, “I take responsibility for solving problems instead of blaming”, mean of 4.73, “I make decisions based on important values”, mean of 4.72, and “I think of solutions even in challenging situations”, mean of 4.69.

Table 21

Top Five Items Ranked by Means

	N	Range	Mean	Std. Error	Std. Deviation
I have integrity	58	1	4.90	.040	.307
I genuinely care about people	59	1	4.83	.049	.378
I take responsibility for solving problems instead of blaming	59	1	4.73	.058	.448
I make decisions based on important values	58	1	4.72	.059	.451
I think of solutions even in challenging situations	59	2	4.69	.065	.500

The lowest rated item when ranked by means was "I am able to talk about what makes me anxious", with a mean of 3.88 as shown in Table 22. The remaining bottom five included, "I use a wide variety of feeling words", mean of 3.95, "I appropriately communicate about emotions with others", mean of 4.00, "I accurately explain why someone feels a particular way", mean of 4.03, and "I discuss the emotional impact of decisions", mean of 4.07. The remaining 27 items had a mean rating higher than "important." Based on a comparison of the top and bottom five it appears that the surveyed physician leaders ranked the importance of ethical problem solving and empathy higher than the importance of discussing emotions. Appendix H contains the rankings of all items by mean score.

Table 22

Bottom Five Items Ranked by Means

	N	Range	Mean	Std. Error	Std. Deviation
I discuss the emotional impact of decisions	59	3	4.07	.093	.716
I accurately explain why someone feels a particular way	59	3	4.03	.108	.830
I appropriately communicate about emotions with others	58	3	4.00	.107	.816
I use a wide variety of feeling words	59	2	3.95	.089	.680
I am able to talk about what makes me anxious	59	4	3.88	.135	1.035

With regard to the standard error of the mean and standard deviation, the item with the highest ranking for both was, “I am able to talk about what makes me anxious”, with a standard error of .135 and standard deviation of 1.035 as shown in Table 23. The remaining top give included, “I am able to explain my feelings”, standard error of .110, standard deviation of .841, “I accurately explain why someone feels a particular way”, standard error of .108, standard deviation of .830, “I appropriately communication about emotions with others”, standard error of .107, standard deviation of .816, and “I see the best in situations”, standard error of .098 and standard deviation of .756.

Table 23

Top Five Items Ranked by Standard Error and Standard Deviation

	N	Range	Mean	Std. Error	Std. Deviation
I am able to talk about what makes me anxious	59	4	3.88	.135	1.035
I am able to explain my feelings	58	4	4.17	.110	.841
I accurately explain why someone feels a particular way	59	3	4.03	.108	.830

Table 23 continued

Top Five Items Ranked by Standard Error and Standard Deviation

	N	Range	Mean	Std. Error	Std. Deviation
I appropriately communicate about emotions with others	58	3	4.00	.107	.816
I see the best in situations	59	2	4.25	.098	.756

The lowest rated item when ranked by standard error of the mean and standard deviation was "I have integrity", with a standard error of .040 and standard deviation of .307 as shown in Table 24. The remaining bottom five included, "I genuinely care about people", standard error of .049 and standard deviation of .378, "I take responsibility for solving problems instead of blaming", standard error of .058 and standard deviation of .448, "I make decisions based on important values", standard error of .059 and standard deviation of .451, and "I think of solutions even in challenging situations", standard error of .065 and standard deviation of .500.

Table 24

Bottom Five Items Ranked by Standard Error and Standard Deviation

	N	Range	Mean	Std. Error	Std. Deviation
I think of solutions even in challenging situations	59	2	4.69	.065	.500
I make decisions based on important values	58	1	4.72	.059	.451
I take responsibility for solving problems instead of blaming	59	1	4.73	.058	.448
I genuinely care about people	59	1	4.83	.049	.378
I have integrity	58	1	4.90	.040	.307

As outlined in Chapter 3, the standard error of the mean, "tells us by how much we would expect our sample means to differ if we use other samples from the same

population" (Gay, et al., 2006, p. 339). The standard deviation is, "the average distance each score is from the average" (Argyrous, 2005, p. 138) and is the most frequently used measure of variation because it, "includes every score in its calculation" (Gay, et al., 2006, p. 309). Given these definitions, when comparing the top and bottom five, the results of this research indicate that the bottom five items would more closely resemble the population of hospitalist medical directors working in outsourced physician services organizations because there is less variation. In addition, for this research it would appear that hospitalist medical directors' view the ability to discuss emotions with more variability than ethically based problem solving when regarding the importance of EI competencies to their leadership.

Descriptive statistics were also calculated for the importance of the EI competencies, EEL, RP, ACT, NE, EIM, EO, and IE. These competencies were determined through the proprietary grouping of the EI survey items. The results were shown in Table 25.

Table 25

Descriptive Statistics for EI Competencies: Importance

	N	Range	Mean	Std. Error	Std. Deviation
Enhance Emotional Literacy (EEL)	58	10	16.17	.327	2.493
Recognize Patters (RP)	59	9	17.10	.286	2.195
Apply Consequential Thinking (ACT)	58	6	13.19	.196	1.492
Navigate Emotions (NE)	58	7	17.93	.245	1.862
Engage Intrinsic Motivation (EIM)	59	4	9.03	.137	1.050
Exercise Optimism (EO)	59	6	18.27	.208	1.596
Increase Empathy (IE)	59	6	18.32	.206	1.580
Valid *N*	57				

Table 25 shows 57 valid responses. This valid *N* is a determination of the total number of participants who answer all of the EI questions used in the calculation of these competences for importance. The range of scores for each competency varied from 4 to 10. When ranked by means, the highest rated competency was “IE”, with a mean of 18.32, while the lowest rated items were, “ACT” with a mean of 13.19 and “EIM” with a mean of 9.03. The remaining four competencies had a mean greater than “important.” This result seems to suggest that the respondents feel the ability to demonstrate empathy is of greater importance to their leadership than applying consequential thinking and motivating themselves.

The competency with the highest standard error of the mean and standard deviation was, “EEL”, with a standard error of .327 and standard deviation of 2.493. The competency with the lowest standard error of the mean and standard deviation was “EIM”, with a standard error of .137 and standard deviation of 1.050. This result seems to suggest that the respondents demonstrated greater dispersion when considering the importance of enhancing emotional literacy in their leadership approach. The respondents

demonstrated less dispersion when considering the importance of intrinsic motivation in their leadership approach. In addition to commenting on the importance of EI to their leadership role, respondents were asked to assess their EI performance.

EI Performance

The second research question in this study was, "How do hospitalist medical directors rate their EI performance?" This question sought to elicit the participants' perception of their EI performance. A Likert-type scale was used in the questionnaire to measure the importance for the 32 EI items. Numbers were assigned to the responses for coding and analysis. The choice of "not important" received a 1, "unimportant" received a 2, "neutral" received a 3, "important" received a 4, and "very important" received a 5. Again, descriptive statistics were employed to assess the participants' perception of their EI performance. The results were shown in Table 26. In addition, a review of the skewness and kurtosis statistics indicated that the data was within acceptable ranges. For skewness the acceptable range is between plus and minus two and for kurtosis the acceptable range is between plus and minus seven (Curran, et al., 1996).

Table 26

Descriptive Statistics for Performance Ordered by Item Number

	N	Range	Mean	Std. Error	Std. Deviation
I notice others feelings	59	2	4.41	.081	.619
I use a wide variety of feeling words	59	2	4.07	.093	.716
I discuss the emotional impact of decisions	59	3	3.95	.109	.839
I make decisions based on important values	58	2	4.64	.068	.520
I accurately describe my own behavior	59	2	4.22	.087	.671
I am proactive take action without having to be pushed by others	59	2	4.36	.093	.713

Table 26 continued

Descriptive Statistics for Performance Ordered by Item Number

	N	Range	Mean	Std. Error	Std. Deviation
I take responsibility for solving problems instead of blaming	59	2	4.54	.074	.567
I see the best in situations	59	3	4.05	.114	.879
I manage my reactions skillfully	59	3	4.05	.095	.729
I am aware of my reactions	58	3	4.28	.088	.670
I talk about the long term vision	59	4	4.27	.113	.868
I set goals that energize me	59	3	4.22	.111	.852
I express emotions appropriately	59	3	4.03	.102	.787
I genuinely care about people	59	2	4.66	.075	.576
I am independent	59	2	4.29	.100	.767
I inspire others with my passion and commitment	59	3	4.25	.104	.801
I am able to talk about what makes me anxious	59	4	3.69	.139	1.071
I accurately explain why someone feels a particular way	59	3	3.76	.112	.858
I adjust easily to new situations	59	3	4.15	.113	.867
I consider the consequences of my behavior on others	59	3	4.41	.103	.790
I am able to explain my feelings	59	4	4.00	.118	.910
I recognize the hot buttons that provoke me	59	4	4.02	.124	.956
I reflect before jumping to decisions	58	3	4.26	.106	.807
I manage my emotions effectively even in difficult situations	58	2	4.10	.097	.742
I think of solutions even in challenging situations	59	3	4.49	.095	.728
I motivate myself	59	2	4.47	.092	.704
I include others feelings when making decisions	58	2	4.31	.093	.706
I appropriately communicate about emotions with others	59	3	3.75	.110	.843
I have integrity	59	2	4.78	.064	.494
I have an intuitive understanding of others	58	3	4.17	.110	.841
I encourage others to be helpful	59	2	4.31	.097	.749
I am truly interested in what others say	59	3	4.41	.103	.790
Valid *N*	56				

Table 26 shows that 56 participants had a valid response for the items regarding their EI performance. This valid *N* is a determination of the total number of participants who answer all of the EI questions regarding performance. The range of scores for each item varied from 2 to 4. Further analysis was conducted on the mean, standard error of the mean, and standard deviation.

With regard to the means, the highest rated item was "I have integrity", with a mean of 4.78 as shown in Table 27. The remaining top five included, "I genuinely care about people", mean of 4.66, "I make decisions based on important values", mean of 4.64, "I take responsibility for solving problems instead of blaming", mean of 4.54, and "I think of solutions even in challenging situations", mean of 4.49.

Table 27

Top Five Items Ranked by Means

	N	Range	Mean	Std. Error	Std. Deviation
I have integrity	59	2	4.78	.064	.494
I genuinely care about people	59	2	4.66	.075	.576
I make decisions based on important values	58	2	4.64	.068	.520
I take responsibility for solving problems instead of blaming	59	2	4.54	.074	.567
I think of solutions even in challenging situations	59	3	4.49	.095	.728

The lowest rated item when ranked by means was "I am able to talk about what makes me anxious", with a mean of 3.69 as shown in Table 28. The remaining bottom five included, "I appropriately communicate about emotions with others", mean of 3.75, "I accurately explain why someone feels a particular way", mean of 3.76, "I discuss the emotional impact of decisions", mean of 3.95, and "I am able to explain my feelings",

mean of 4.00. The remaining 27 items had a mean rating higher than "important." Based on a comparison of the top and bottom five it appears that the surveyed physician leaders ranked their ability to problem solve with integrity and empathy higher than their ability to express and articulate their feelings. Appendix I contains the rankings of all items by mean score.

Table 28

Bottom Five Items Ranked by Means

	N	Range	Mean	Std. Error	Std. Deviation
I am able to explain my feelings	59	4	4.00	.118	.910
I discuss the emotional impact of decisions	59	3	3.95	.109	.839
I accurately explain why someone feels a particular way	59	3	3.76	.112	.858
I appropriately communicate about emotions with others	59	3	3.75	.110	.843
I am able to talk about what makes me anxious	59	4	3.69	.139	1.071

With regard to the standard error of the mean and standard deviation, the item with the highest ranking for both was, "I am able to talk about what makes me anxious", with a standard error of .139 and standard deviation of 1.071 as shown in Table 29. The remaining top give included, "I recognize the hot buttons that provide me", standard error of .124, standard deviation of .956, "I am able to explain my feelings", standard error of .118, standard deviation of .910, "I see the best in situations", standard error of .114, standard deviation of .879, and "I talk about the long term vision", standard error of .113 and standard deviation of .868.

Table 29

Top Five Items Ranked by Standard Error and Standard Deviation

	N	Range	Mean	Std. Error	Std. Deviation
I am able to talk about what makes me anxious	59	4	3.69	.139	1.071
I recognize the hot buttons that provoke me	59	4	4.02	.124	.956
I am able to explain my feelings	59	4	4.00	.118	.910
I see the best in situations	59	3	4.05	.114	.879
I talk about the long term vision	59	4	4.27	.113	.868

The lowest rated item when ranked by standard error of the mean and standard deviation was “I have integrity”, with a standard error of .064 and standard deviation of .494 as shown in Table 30. The remaining bottom five included, “I make decisions based on important values”, standard error of .068 and standard deviation of .520, “I take responsibility for solving problems instead of blaming”, standard error of .074 and standard deviation of .567, “I genuinely care about people”, standard error of .075 and standard deviation of .576, and “I notice others feelings”, standard error of .081 and standard deviation of .619.

Table 30

Bottom Five Items Ranked by Standard Error and Standard Deviation

	N	Range	Mean	Std. Error	Std. Deviation
I notice others feelings	59	2	4.41	.081	.619
I genuinely care about people	59	2	4.66	.075	.576
I take responsibility for solving problems instead of blaming	59	2	4.54	.074	.567
I make decisions based on important values	58	2	4.64	.068	.520
I have integrity	59	2	4.78	.064	.494

As outlined in Chapter 3, the standard error of the mean, "tells us by how much we would expect our sample means to differ if we use other samples from the same population" (Gay, et al., 2006, p. 339). The standard deviation is, "the average distance each score is from the average" (Argyrous, 2005, p. 138) and is the most frequently used measure of variation because it, "includes every score in its calculation" (Gay, et al., 2006, p. 309). Given these definitions, when comparing the top and bottom five, the results of this research indicate that the bottom five items would more closely resemble the populations of hospitalist medical directors working in outsourced physician services organizations. For this research it would appear that hospitalist medical directors view their ability to discuss emotions with more variability than their ability to problem solve with integrity and empathy.

Descriptive statistics were also calculated for the performance on the EI competencies, EEL, RP, ACT, NE, EIM, EO, and IE. These competencies were determined through the proprietary grouping of the EI survey items. The results were shown in Table 31.

Table 31

Descriptive Statistics for EI Competencies: Performance

	N	Range	Mean	Std. Error	Std. Deviation
Enhance Emotional Literacy (EEL)	59	10	15.58	.332	2.548
Recognize Patterns (RP)	58	10	16.19	.331	2.523
Apply Consequential Thinking (ACT)	58	7	12.67	.248	1.886
Navigate Emotions (NE)	58	10	16.33	.316	2.409
Engage Intrinsic Motivation (EIM)	59	5	8.58	.176	1.354
Exercise Optimism (EO)	59	8	17.39	.266	2.043
Increase Empathy (IE)	58	8	17.66	.259	1.970
Valid *N*	57				

Table 31 indicated 57 valid responses. This valid *N* is a determination of the total number of participants who answer all of the EI questions used in the calculation of these competences for performance. The range of scores for each competency varied from 5 to 10. The highest rated competency was "IE", with a mean of 17.66, while the lowest rated items were, "EEL" with a mean of 15.58, "ACT" with a mean of 12.67, and "EIM", with a mean of 8.58. The remaining three competencies had a mean greater than "important." This result seems to suggest that the respondents feel that their ability to demonstrate empathy is greater than their ability to be proactive, apply consequential thinking, and discuss emotions.

The competency with the highest standard error of the mean and standard deviation was, "EEL", with a standard error of .332 and standard deviation of 2.548. The competency with the lowest standard error of the mean and standard deviation was "EIM", with a standard error of .176 and standard deviation of 1.354. This result seems to suggest that the respondents demonstrated greater dispersion when considering their ability to articulate and discuss emotions. The respondents demonstrated less dispersion when considering their ability to demonstrate empathy. To gain greater clarity regarding these results, participants were invited to contribute narrative responses through an additional comment area.

Narrative Reponses

For each of the 32 EI item an "additional comment" area was provided. This area was intended to collect clarifying narrative that could provide additional context for the numerical ratings. This area was optional and respondents were instructed by the following, "To clarify your answers, you are invited to provide written comments for

each question." The compiled results for all EI items were shown in Appendix B. A sample of the responses included the following, for the item, "I use a wide variety of feeling words", a participant responded, "I am more concerned about accurate information than putting a certain "feeling" about the information." For the item, "I make decisions based on important values", a participant noted, "Requests for hospitalists behavior change/availability comes from all directions. Patient Care Quality, productivity to minimize loss for the hospital, prevention of burnout of team members are just a few of the values that must be considered regularly." For the item, "I take responsibility for solving problems instead of blaming", a participant commented, "Root cause analysis participation is a tool for investigating for systems issues before counseling an individual." For the item, "I genuinely care about people", a participant responded, "Not truly valued by the payers of healthcare, but are to patients/families and nurses." Finally, for the item, "I appropriately communicate about emotions with others," a participant articulated:

> To effectively manage, you need to check emotions at the door and use them as a tool, if I get angry or frustrated or the opposite, I risk alienating someone who may feel the same event in a different light.

These narrative responses assisted in providing insight into how participants perceived their leadership role.

EI Competences and Perceptions of Leadership Role

The third research question was, "How do self-reported EI competencies correlate to hospitalist medical directors' perceptions of their leadership role?" The intent of this question was to relate the hospitalist success factor and demographic responses to the EI

competencies. Correlation was used to analyze the relation between EI competencies and hospitalist success factors and ANOVA was used to analyze the interaction between EI competencies and demographics. The first analysis will be regarding EI and the hospitalist program success questions.

EI and Hospitalist Program Success

Correlations exist, "if, when one variable increases, another variable either increases or decreases in a somewhat predictable fashion" (Leedy & Ormrod, 2005, p. 180). Correlation has also been defined as, "A measure of relationships between variables describing the direction and degree of association between them" (Robson, 2002, p. 546). The correlation table for hospitalist success factor questions and EI competencies was shown in Table 32.

Table 32

Correlations for Hospitalist Success Factors and EI Competencies

Hospitalist Success Factors		EEL	RP	ACT	NE	EIM	EO	IE
I make decisions that lead to positive results	Pearson Correlation	0.245	0.208	0.046	-0.069	-0.032	0.215	0.150
	Sig. (2-tailed)	0.067	0.125	0.739	0.611	0.816	0.108	0.270
	N	57	56	56	56	57	57	56
Length of stay at the hospital has been reduced	Pearson Correlation	0.144	0.047	0.046	0.057	0.173	.284*	0.048
	Sig. (2-tailed)	0.287	0.732	0.734	0.678	0.198	0.032	0.727
	N	57	56	56	56	57	57	56
Quality of care indicators have improved	Pearson Correlation	0.142	0.007	0.092	0.027	.329*	0.224	0.137
	Sig. (2-tailed)	0.298	0.960	0.502	0.846	0.013	0.097	0.319
	N	56	55	55	55	56	56	55
Cost of hospitalization has been reduced	Pearson Correlation	0.154	0.101	0.144	0.029	0.221	0.234	0.201
	Sig. (2-tailed)	0.256	0.463	0.294	0.835	0.101	0.083	0.141
	N	56	55	55	55	56	56	55

Table 32 continued

Correlations for Hospitalist Success Factors and EI Competencies

Hospitalist Success Factors		EEL	RP	ACT	NE	EIM	EO	IE
Patient satisfaction scores have improved	Pearson Correlation	-0.016	0.034	0.256	-0.062	0.035	0.065	0.180
	Sig. (2-tailed)	0.906	0.81	0.062	0.658	0.799	0.639	0.193
	N	55	54	54	54	55	55	54
My time spent on direct patient care is appropriate	Pearson Correlation	-0.264	-0.240	-0.121	-0.011	-0.008	-0.059	-0.229
	Sig. (2-tailed)	0.053	0.081	0.385	0.939	0.955	0.673	0.095
	N	54	54	54	53	54	54	54
My time spent on administration (i.e. budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate	Pearson Correlation	0.009	0.14	0.096	.354**	0.206	0.234	0.085
	Sig. (2-tailed)	0.948	0.311	0.491	0.009	0.131	0.086	0.541
	N	55	54	54	54	55	55	54

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 32 demonstrated there was a weak correlation between the "length of stay at the hospital has been reduced" and Exercise Optimism (EO) (r = .284, n =57, p = .05). In addition, there was a weak to moderate correlation between "quality of care indicators have improved" and Engage Intrinsic Motivation (EIM) (r = .329, n =56, p = .05). Finally, there was a weak to moderate correlation between "my time spent on administration (i.e. budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate" and Navigate Emotions (NE) (r = .354, n =54, p = .01). In addition to reviewing the relationship between EI and hospitalist program success the relationship between EI and demographics was also investigated.

EI and Demographics

ANOVA was used to analyze the differences between demographic groups and EI competencies. ANOVA is a test, "of significance used to determine whether a significant difference exists between two or more means at a selected probability level" (Gay, et al., 2005, p. 359). In this study, each demographic question segmented the respondents into two or more groups. The results of the ANOVA analysis were shown in Appendix G. In summary, across EI competencies and demographic questions there were no significant results from the ANOVA analysis with the exception of Apply Consequential Thinking (ACT) and "number of individuals that report directly to you". There was a significant effect of "number of individuals that report directly to you" on ACT at the $p < .05$ level for the conditions [F (2, 51) = 3.319, p = .044]. A post hoc comparison was conducted using Bonferroni. This test indicated that there was a significant difference in ACT and 11+ individuals reporting to the leader.

Conclusions

The first research question of this study sought to identify the EI competencies that hospitalist medical directors perceived to be important to their leadership role. Descriptive statistics including the range, mean, standard error of the mean and standard deviation were used to assess the importance and were shown in Table 20. The top five rated items included, "I have integrity" (mean = 4.90), "I genuinely care about people" (mean = 4.83), "I take responsibility for solving problems instead of blaming" (mean = 4.73), "I make decisions based on important values" (mean = 4.72), and "I think of solutions even in challenging situations" (mean = 4.69). The bottom five rated items included, "I am able to talk about what makes me anxious" (mean = 3.88), "I use a wide variety of feeling words" (mean = 3.95), "I appropriately communicate about emotions with others" (mean = 4.00), "I accurately explain why someone feels a particular way" (mean = 4.03), and "I discuss the emotional impact of decisions" (mean 4.07). The complete ranking of means for importance was shown in Appendix H. Based on these findings, the surveyed physician leaders ranked the importance of ethical problem solving higher than the importance of discussing emotions.

This conclusion was supported by several of the narrative comments. One participant stated, "I am more concerned about accurate information than putting a certain 'feeling' about the information." Another articulated that, "Root cause analysis participation is a tool for investigating for systems issues before counseling an individual." Finally, a participant commented:

> To effectively manage, you need to check emotions at the door and use them as a tool, if I get anger or frustration or the opposite, I risk alienating someone who may feel the same event in a different light.

Other research studies have also suggested similar results. Grossman (2000) stated that;

> Health care suffers from having medical doctors as managers. Doctors are very smart, used to finding the answers themselves. But, they're not necessarily smart around the soft side of people. They've gotten by on their intellect, tenacity, and analytical problem-solving. (p. 19)

McMullen (2002) proposed that the lack of dialogue regarding emotions may be linked to medical education that, "is an environment where 'real' doctors get on with the job and only the weak weep or feel distressed" (p. 170). The current study's findings appear to mirror these research studies.

The second research question of this study was to identify how hospitalist medical directors rated their EI performance. Again, descriptive statistics including the range, mean, standard error of the mean and standard deviation were used to assess performance and were shown in Table 26. The top five rated items included, "I have integrity" (mean 4.78), "I genuinely care about people" (mean = 4.66), "I make decisions based on important values" (mean = 4.64), "I take responsibility for solving problems instead of blaming" (mean = 4.54), and "I think of solutions even in challenging situations" (mean = 4.49). The bottom five rated items included, "I am able to talk about what makes me anxious" (mean = 3.69), "I appropriately communicate about emotions with others" (mean = 3.75), "I accurately explain why someone feels a particular way" (mean = 3.76),

“I discuss the emotional impact of decisions” (mean = 3.95), and “I am able to explain my feelings” (mean = 4.00). A complete rank ordering of the means for performance was shown in Appendix E. Based on these findings the participants ranked their problem-solving performance higher than their performance in emotional dialogue.

This conclusion was also supported by several of the narrative comments. One participant commented, “If I understood the question – sometimes I discuss with others but I myself think, observe and feel.” Others expressed, “I tend to keep these thoughts [talking about what makes you anxious] to myself” and “Sometimes hide feelings.”

As discussed earlier, these findings were also supported by previous studies. Meyer, et al., (2004) suggested that the, “underpinnings of medical and health science education ignore interpersonal and communication skills in favor of natural science knowledge and technological skills" (p. 226). Finally, Lewis, et al., (2005) found that;

> Although it makes sense that an ability to recognize and manage emotion in oneself and others is an important skill for doctors, there is a tangible tension in medicine concerning the whole field of emotion in practice. Traditionally, detachment has been valued in medicine, reflecting a belief that emotions will somehow interfere with a doctor's ability to carry out his or her job. An argument is often made that doctors must maintain distance from patients in order to generate objectivity in diagnosis and treatment. (p. 341)

After analyzing the means for importance and performance separately, the gap between importance and performance of the individual EI items was reviewed to provide further insight into the first two research questions of this study. The participants rated the importance of all items higher than their performance with the exception of the

question, “I use a wide variety of feeling words.” A gap analysis of the EI item means is show in Table 33.

Table 33

Gap Analysis: Individual Items Ordered by Item

	Mean Importance	Mean Performance	Difference
I notice others feelings	4.54	4.41	0.13
I use a wide variety of feeling words	3.95	4.07	-0.12
I discuss the emotional impact of decisions	4.07	3.95	0.12
I make decisions based on important values	4.72	4.64	0.08
I accurately describe my own behavior	4.29	4.22	0.07
I am proactive take action without having to be pushed by others	4.59	4.36	0.23
I take responsibility for solving problems instead of blaming	4.73	4.54	0.19
I see the best in situations	4.25	4.05	0.20
I manage my reactions skillfully	4.47	4.05	0.42
I am aware of my reactions	4.58	4.28	0.30
I talk about the long term vision	4.54	4.27	0.27
I set goals that energize me	4.44	4.22	0.22
I express emotions appropriately	4.37	4.03	0.34
I genuinely care about people	4.83	4.66	0.17
I am independent	4.47	4.29	0.18
I inspire others with my passion and commitment	4.56	4.25	0.31
I am able to talk about what makes me anxious	3.88	3.69	0.19
I accurately explain why someone feels a particular way	4.03	3.76	0.27
I adjust easily to new situations	4.47	4.15	0.32
I consider the consequences of my behavior on others	4.60	4.41	0.19
I am able to explain my feelings	4.17	4.00	0.17
I recognize the hot buttons that provoke me	4.36	4.02	0.34
I reflect before jumping to decisions	4.60	4.26	0.34
I manage my emotions effectively even in difficult situations	4.60	4.10	0.50

Table 33 continued

Gap Analysis: Individual Items Ordered by Item

	Mean Importance	Mean Performance	Difference
I think of solutions even in challenging situations	4.69	4.49	0.20
I motivate myself	4.68	4.47	0.21
I include others feelings when making decisions	4.51	4.31	0.20
I appropriately communicate about emotions with others	4.00	3.75	0.25
I have integrity	4.90	4.78	0.12
I have an intuitive understanding of others	4.37	4.17	0.20
I encourage others to be helpful	4.59	4.31	0.28
I am truly interested in what others say	4.58	4.41	0.17

The items with the largest gap between importance and performance included, "I manage my emotions effectively even in difficult situations" (gap = .50), "I manage my reactions skillfully" (gap = .42), "I express emotions appropriately" (gap = .34), "I recognize the hot buttons that provoke me" (gap = .34), and "I reflect before jumping to decisions" (gap = .34). The items with the smallest gaps included, "I use a wide variety of feeling words" (gap = -0.12) "I accurately describe my own behavior" (gap = .07), "I make decisions based on important values" (gap = .08), "I have integrity" (gap = .12), and "I discuss the emotional impact of decisions" (gap = .12). A complete ranking of the gaps was shown in Appendix J.

These gaps suggest that the participants were aware of the importance of controlling and managing their emotions yet may have difficulty in executing this control. Again, narrative responses supported this conclusion. One respondent suggested, "I am working in this area [managing my reactions skillfully]. I have a gut

fear/intimidation reaction with one of my colleagues. Learning to drop the defensiveness and move to dialogue." Another reflected, "I do not blow up but I will show irritation when I believe it to be justified. I likewise will repress this if necessary." Pierce (2000) seemed to suggest that controlling and managing emotion was critical for physician leadership when stating that an effective physician leader would have, "the capability of managing frustration, anxiety, conflict, and operating at the edge of chaos by balancing productivity with innovation" (p. 25). Goleman and Boyatzis (2008) supported the importance of emotional management when they proposed, "leading effectively is…about developing a genuine interest in and talent for fostering positive feelings in the people whose cooperation and support you need" (p. 76).

While the first gap analysis focused on the individual EI items a second gap analysis was conducted and focused specifically on the EI competencies. Again, these competencies were developed through a proprietary group of the 32 EI items. Table 34 shows the results of these calculations ranked in order from largest to smallest.

Table 34

Gap Analysis: EI Competencies

	Mean Importance	Mean Performance	Difference
Navigate Emotions (NE)	17.93	16.33	1.60
Recognize Patterns (RP)	17.10	16.19	0.91
Exercise Optimism (EO)	18.27	17.39	0.88
Increase Empathy (IE)	18.32	17.66	0.66
Enhance Emotional Literacy (EEL)	16.17	15.58	0.59
Apply Consequential Thinking (ACT)	13.19	12.67	0.52
Engage Intrinsic Motivation (EIM)	9.03	8.58	0.45

Table 34 shows that the largest gaps between importance and performance were for the EI competencies navigating emotions and recognizing patterns. Navigating emotions is defined as, "Accurately identifying and interpreting both simple and compound feelings" (Freedman, 2010, para. 12). Recognizing patterns is defined as, "Acknowledging frequently recurring reactions and behaviors." Both of these competencies compose the Know Yourself EI pursuit which is the ability to notice what you do with regard to emotions. These results suggest that the participants view their ability to recognize, identify, and acknowledge their emotions to be trailing the importance that this could play in their leadership.

The smallest gaps between importance and performance were for engaging intrinsic motivation and applying consequential thinking. Engaging intrinsic motivation is defined as, "gaining energy from personal values and commitments vs. being driven by external forces" (Freedman, 2010, para. 12). Applying consequential thinking is defined as, "evaluating the costs and benefits of your choices" (Freedman, 2010, para. 12). Both of these competencies compose the Choose Yourself EI pursuit which is the ability to do what you mean. These results suggest that the participants tend to do what they say they will do, a key component for establishing leadership credibility (Kouzes & Posner, 1993). A second conclusion could be that the participants viewed these competencies as less important to their leadership, thus expended less effort in their performance of each.

The third research question sought to identify the relationship between self-reported EI competencies and the respondents' perceptions of their leadership role. As indicated earlier, two statistical techniques were used including correlation and ANOVA. Correlation was used to analyze the relationship between EI competencies and hospitalist

success factors. ANOVA was used to analyze the interaction between EI competencies and demographics. Both of these analyses yield little significance. All significant ($p < .05$ or $p < .01$) correlations were weak to moderate and the ANOVA results did not demonstrate significance with the exception of one comparison.

Given these results, no statistically significant conclusions could be reached regarding several hypothesized findings suggested in Chapter 1. The researcher hypothesized finding positive correlation between the EI pursuit Know Yourself which is comprised of the EI competencies EEL and RP and the medical directors' length of tenure as a leader in their organization. This suggested finding was based on research indicating that EI can be developed over time (Carmeli, et al., 2008). This conclusion was not supported.

The EI pursuit Choose Yourself which is comprised of the EI competencies ACT, NE, EIM, and EO was hypothesized to be positively correlated to number of years as a hospitalist, number of years at the hospital, and number of years as a hospitalist medical director based on the medical directors' choice of the organization and role. This conclusion was not supported. However, there was significance at the $p < .05$ level regarding ACT and "number of individuals that report direct to you" [F (2, 51) = 3.319, p = .044]. A post hoc comparison was conducted using Bonferroni. This test indicated that there was a significant difference in ACT and 11+ individuals reporting to the leader. This result may indicate that when hospitalist medical directors lead larger staffs they are taking greater care in evaluating the consequences of various choices.

Finally, the EI competency Give Yourself which is comprised of IE, was hypothesized to be positively correlated to staff size as the use of EI may be needed more

frequently when working with a larger staff (Carmeli, 2003). Again, this hypothesized finding was not supported. These conclusions highlight the multidimensional nature of the EI construct as discussed in Chapter 2.

Implications and Recommendations

A finding of this research is that the hospitalist medical directors believed EI to be important for leadership. All EI items were rated above the "important" ranking with the exception of "I use a wide variety of feeling words" and "I am able to talk about what makes me anxious." The ratings of these two items may demonstrate a bias based on physician training and education (McMullen, 2002). The high rankings on the remaining items suggested that the participants recognize the impact EI has on leadership success. This conclusion has been supported by previous research (Boyatzis, 1999; Carmeli, et al., 2008; Dearborn, 2002; Druskat & Wolff, 2001; Goleman, 1998a; "The 2003 HBR", 2003; Jordan & Troth, 2004; Kelley & Caplan, 1993).

The research findings also demonstrated that the survey participants ranked their performance of EI lower than the importance they believe EI plays in their "ideal" leadership approach. This could be an indication that participants acknowledge that improvement could be made in their ability to effectively use and demonstrate EI. Therefore, training and development opportunities for hospitalist medical directors could focus on enhancing EI competencies. This training could be provided through a variety of avenues including the addition of EI curriculum in medical school, workshops and seminars offered as continuing education credit, and one-on-one leadership coaching that includes EI concepts and self-awareness activities.

This study also demonstrated that further research regarding EI and physician leadership should be conducted. The promising results demonstrated in leadership studies linking EI to high performance in other industries was an indicator that EI could assist physician leaders in improving their own and their organization's performance (Abraham, 2004; Boyatzis, 1999; Carmeli, et al., 2008; Carmeli, & Josman, 2006; Checkland, 2004; Cherniss, 2000; Dearborn, 2002; Goleman, 1998a; Hawkins & Dulewicz, 2007; Kelley & Caplan, 1993; Pearman, 2002; Williams, 2008). In addition, EI has already been shown to improve physician to patient interaction therefore this would suggest that physician leaders could use EI to improve interaction with other stakeholders in their organizations (Austin, et al., 2007; Deshpande & Joseph, 2009; Fariselli, et al., 2008; Freshwater & Stickley, 2004; Smith, et al., 2008; Wagner, et al., 2002).

It would be important for future researchers to employ a multi-rater approach when exploring EI and leadership. Bailey and Austin (2006) proposed that "utilizing such systems [multirater feedback] for employee development, organizations are tacitly endorsing an assumption of many learning theories -- that providing feedback on performance will result in improvements in individuals' subsequent performance" (p. 51). Surveying those that are being led and those that interact with a leader regarding their perceptions of the leader's EI performance would provide valuable insight for both the leader's and the organization's development. Church and Bracken (1997) determined that:

> Many organizations today are using 360-degree feedback systems, a specific form of the general category of multirater assessment or multisource feedback (MSF), for a variety of purposes, including: leadership and management development,

> performance appraisal and/or performance management systems, measuring client and customer-related behaviors and perceptions, succession planning, general culture assessment, and organizational-change initiatives. (p. 150)

It would also be important for future researchers to utilize data collected by hospitals and other groups regarding the performance of the medical directors. In this survey the "hospitalist success factors" were self-reported. In future research the "hospitalist success factors" could be determined, for example, by Press-Ganey scores, hospital data, and data collected by the outsourced physician services organizations. By using this data the comparison would be based on objective performance measures rather than perceptions of success.

Another exploration for further research would be to use additional statistical techniques. One such technique would be the analysis of covariance (ANCOVA). ANCOVA is a, "technique for controlling extraneous variables" (Gay, et al., 2006). The technique adjusts scores and essentially "levels the playing field". For example, perhaps the comparison of EEL and number of years at your current organization is being influenced by the variable, number of years in your current leadership role. ANCOVA would adjust the comparison by moderating the effect of number of years in your current leadership role.

As with any research that focuses on one population, the ability to generalize the research findings to other populations may be difficult (Gay, et al., 2006). Future researchers may be interested in expanding the scope of physician leaders beyond hospitalist medical directors, managing three or more hospitalist physicians, working in multistate, outsourced physician services organizations. By broadening the population to

include other physician leaders suggestions could be determined that would have the potential of improving other areas of the healthcare system.

The challenges facing the healthcare system in the United States continue to evolve and raise expectations for physician leaders. These leaders play a vital role in the effective and efficient functioning of their organizations (Beckham, 1995). They serve at the intersection of clinical care and business realities thus have a unique place and ability to influence organizations to both improve quality of healthcare and business performance (Gerbarg, 2002). As highlighted previously, deficient leadership negatively impacts organizations which, in turn, can impact the performance of the healthcare industry (Greeno, 2003). Physician leaders would be well served to focus on developing their leadership acumen and EI training could be an effective leadership tool and topic for research.

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Appendix A

Written Permission for SEI 360 Feedback

Written Permission for SEI 360 Feedback

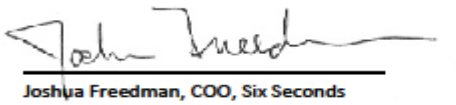
March 14, 2009

Josh Freedman
Six Seconds
9099 Soquel Ave #6
Aptos, CA 95003

Dear Josh:

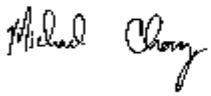
I am writing to seek your permission to use the SEI 360 Report for my dissertation research that I am conducting through the Doctoral program at Olivet Nazarene University. The item allocations (which items go to which scale) will remain confidential.

Please sign this form and return to my address below.



Joshua Freedman, COO, Six Seconds

Regards,



Michael Cherry
946 S. Kensington Ave.
La Grange, IL 60525

Appendix B

Survey Questionnaire

Survey Questionnaire

You are taking a self-assessment. Before you start, take a moment to reflect on your characteristics and behaviors as you relate to others and how important these characteristics and behaviors are for your leadership role.

Beside each statement, you'll find the scales below:

1 Not Important/Disagree

2 Unimportant/Disagree Slightly

3 Neutral/Neutral

4 Important/Agree Slightly

5 Very Important/Agree

To clarify your answers, you are invited to make a comment or provide an example about each in the space provided.

How true is each of these statements about you?

I…

Importance						Statement	Performance					
1	2	3	4	5			1	2	3	I4	5	Comments
					1	Notice others' feelings						
					2	Use a wide variety of feeling words						
					3	Discuss the emotional impact of decisions						
					4	Make decisions based on important values						
					5	Accurately describe my own behavior						
					6	Am proactive (take action without having to be pushed by others)						
					7	Take responsibility for solving problems instead of blaming others						

					8	See the best in situations						
					9	Manage my reactions skillfully						
					10	Am aware of my reactions						
					11	Talk about the long-term vision						
					12	Set goals that energize me						
					13	Express emotions appropriately						
					14	Genuinely care about people						
					15	Am independent						
					16	Inspire others with my passion and commitment						
					17	Am able to talk about what makes me anxious						
					18	Accurately explain why someone feels a particular way						
					19	Adjust easily to new situations						
					20	Consider the consequences of my behavior on others						

					21	Am able to explain my feelings						
					22	Recognize the “hot buttons” that provoke me						
					23	Reflect before jumping to decisions						
					24	Manage my emotions effectively even in difficult situations						
					25	Think of solutions even in challenging situations						
					26	Motivate myself						
					27	Include others’ feelings when making decisions						
					28	Appropriately communicate about emotions with others						
					29	Have integrity						
					30	Have an intuitive understanding of others						

					31	Encourage others to be helpful						
					32	Am truly interested in what others say						

Next, please objectively answer how much you agree with the following statements.

Since I have become a medical director…

	Item	**Performance**					
		1	2	3	4	5	Comments
33	I make decisions that lead to positive results.						
34	Length of stay at the hospital has been reduced.						
35	Quality of care indicators have improved.						
36	Cost of hospitalization has been reduced.						
37	Patient satisfaction scores have improved.						
38	My time spent on direct patient care is appropriate.						
39	My time spent on administration (i.e., budgets, strategic planning, employee evaluations, policies and procedures, and committees) is appropriate.						

Demographics

40	Hospital Location?	Urban	Suburban	Rural							
41	Number of inpatient beds in your hospital?	Range									
42	Number of years as a physician?	0-5	6-10	11-15	16-20	20+					
43	Number of years as a hospitalist?	0-5	6-10	11+							
44	Number of years at your current organization?	0-5	6-10	11-15	16-20	20+					
45	Number of years in your current leadership position?	0-5	6-10	11+							
46	Was your current leadership position appointed or voluntary?	Appointed	Voluntary								
47	Number of individuals that report directly to you?	Number									

Appendix C

Opening Email and Intent to Participate

Opening Email and Intent to Participate

Dear Colleague:

We are writing to encourage you to participate in a leadership study opportunity. This research explores the use of emotional intelligence competencies in your leadership role as Medical Director. The research is being conducted as part of a doctoral program and we believe the results will be a benefit to your leadership and our organization.

Below you will find more information regarding this study.

Research Title: Health Care Leadership: Emotional Intelligence Competencies of Hospitalist Leaders.

Purpose: The purpose of this study is to determine Hospitalist Medical Directors performance on Emotional Intelligence (EI) competencies and the importance of these competencies to their leadership role.

Time Commitment: The survey will take between 25-30 minutes to complete. Follow-up phone calls may be conducted but will not exceed 30 minutes in length.

Procedures: Please review this email and click on the weblink below to enter the survey instrument.

<SURVEY_LINK>

Confidentiality: The data from this survey will only be used in aggregate form. Individual answers will not be identified.

If you have any questions regarding this research please contact Mike Cherry at the numbers listed below.

Thank you, in advance, for your participation in this important and valuable work.

Organizational contact name

Michael Cherry

Doctoral Candidate

815.836.5562

Appendix D

Informed Consent

Informed Consent

Project Title: Health Care Leadership: Emotional Intelligence Competencies of Hospitalist Leaders

Investigator: Michael Cherry, Department of Graduate and Continuing Studies, 815.836.5562

You are being asked to participate in a project conducted through Olivet Nazarene University and your organization. The University requires that you give your agreement to participate in this project.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please indicate your willingness by clicking on the agreement link. Please print a copy of this page to keep.

1. Nature and Purpose of the Project:

You have been asked to participate in a research study conducted by Michael Cherry, a doctoral student in the Ed.D. Ethical Leadership program at Olivet Nazarene University. This research involves the study of the importance of and use of emotional intelligence in your leadership role as Medical Director and is part of Michael Cherry's dissertation. You have been selected for this study because of the role you play in the organization.

2. Explanation of Procedures:

This study involves completing a written survey that will be delivered electronically and is expected to last approximately 20-30 minutes. Follow up interviews may need to be scheduled hence, the total time involved in participation will be no more than 1 hour.

3. Discomfort and Risks:

Participants do face some potential risks or costs. First, my asking you to respond openly about your leadership approach may be intimidating. You will be free to withdraw from the research at any time. Your information will be anonymous. The quantitative approach was selected in part because it enables the integration of the research data further enhancing confidentiality. Second, you must give of your time to take part in this research. The sacrifice may be mitigated by the opportunity to review the summary results. Third, the potential for psychological, economic, emotional, or physical harm is remote. The research will address topics that are part of your normal routine.

4. Benefits:

The participants of this research may receive several benefits. First, you may gain the satisfaction of participating in research in an area of strong personal interest to you – your leadership. Second, the activity may lead you to think deeply about your work environment and approach. Such introspection may help you better understand how to succeed in the environment. You may develop greater personal awareness of the nature of the organization in which you work as a result of your participation in this research.

5. Confidentiality:

The information you provide will be kept strictly confidential. Only the researcher, a Faculty Supervisor, and a confidential Research Assistant will have access to this information.

A generic name will be assigned to any quotes that might be included in the final research report. The research material will be kept in a secure location and destroyed after completion of the study.

The results of this research will be published in my dissertation and possibly in subsequent journals or books.

6. Refusal/Withdrawal:

Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE OLIVET NAZARENE UNIVERSITY INSTITUTIONAL REVIEW BOARD ON AUGUST 1, 2009.

Thank you very much for your time and support. Please start with the survey now by clicking on the **Continue** button below. If you do not wish to participate simply close the survey.

Appendix E

Frequency Tables for Demographic Questions

Frequency Tables for Demographic Questions

Q40: Hospital location					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Urban	12	20.3	21.4	21.4
	Suburban	31	52.5	55.4	76.8
	Rural	13	22.0	23.2	100.0
	Total	56	94.9	100.0	
Missing	0	3	5.1		
Total		59	100.0		

Q67: Revised number of inpatient beds in your hospital					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-100	11	18.6	20.0	20.0
	101-200	23	39.0	41.8	61.8
	201+	21	35.6	38.2	100.0
	Total	55	93.2	100.0	
Missing	System	4	6.8		
Total		59	100.0		

Q65: Revised Years as a physician					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5	10	16.9	17.9	17.9
	6-10	12	20.3	21.4	39.3
	11+	34	57.6	60.7	100.0
	Total	56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

Q43: Number of years as a hospitalist					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5	32	54.2	57.1	57.1
	6-10	15	25.4	26.8	83.9
	11+	9	15.3	16.1	100.0
	Total	56	94.9	100.0	
Missing	0	3	5.1		
Total		59	100.0		

Q66: Revise Years at your current organization					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5	36	61.0	64.3	64.3
	6-10	13	22.0	23.2	87.5
	11+	7	11.9	12.5	100.0
	Total	56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

Q45: Number of years in your current leadership position					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5	47	79.7	83.9	83.9
	6-10	8	13.6	14.3	98.2
	11+	1	1.7	1.8	100.0
	Total	56	94.9	100.0	
Missing	0	3	5.1		
Total		59	100.0		

Q46: Was your current leadership position appointed or voluntary					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Appointed	38	64.4	67.9	67.9
	Voluntary	18	30.5	32.1	100.0
	Total	56	94.9	100.0	
Missing	0	3	5.1		
Total		59	100.0		

Q68: Revised number of individuals that report directly to you					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-5	20	33.9	36.4	36.4
	6-10	21	35.6	38.2	74.5
	11+	14	23.7	25.5	100.0
	Total	55	93.2	100.0	
Missing	System	4	6.8		
Total		59	100.0		

Appendix F

Narrative Responses by Question

Narrative Responses by Question

Q1. I notice others' feelings

- My personality tends to be sensitive to other people's needs & state of mind. I tend to inquire if there is tension or high emotion.
- we are in a profession that entirely deals with human beings

Q2. I use a wide variety of feeling words

- Some examples would clarify this question
- I'm not really sure what you mean with 'variety of feeling words'
- I am more concerned about accurate information than putting a certain 'feeling' about the information

Q3. I discuss the emotional impact of decisions

- Satisfaction in the hospitalist role includes feelings of self worth, belonging to a group, having some input on major decisions.
- I frequently but not always do this.
- If I understood question – sometimes I discuss with others about it but I myself think, observe and feel about it.

Q4. I made decisions based on important values

- Whose values, mine, the patient, the provider? Example, tube feeding a demented patient, my values, the patients, the families, and the nurses may all vary.
- Requests for hospitalists behavior change/availability comes from all directions. Patient Care Quality, productivity to minimize loss for the hospital, prevention

of burnout of team members are just a few of the values that must be considered regularly.

- I like to think that I do this every time.
- Principles should guide all forms of behavior in my view.

Q5. I accurately describe my own behavior

- As a leader, I must walk the talk.

Q6. I am proactive (take action without having to be pushed by others)

- That is necessary in this position.
- I am willing to take action but not immediately. Often things sort out on their own if given a little time

Q7. I take responsibility for solving problems instead of blaming

- Solving problems can lead to being seen as being an agitator in a hospital or company.
- Root cause analysis participation is a tool for investigating for systems issues before counseling an individual.
- Blaming others does not get the job done.
- One thing to mention. I talk with the responsible people about the problem, not to blame but to avoid it happening in future again.
- I accept responsibility for my actions but do not like to take the fall for others mistakes.

Q8. I see the best in situations

- Tend to expect the best of people, and give the benefit of doubt if they fall short.
- I am the opposite.

- I try to do this always. Sometimes it is hard.
- Try to see the best but will readily shift to objective view.
- I know optimism is key but I have an ability to see the potential for things going wrong.

Q9. I manage my reactions skillfully

- I am working in this area. I have a gut fear/intimidation reaction with one of my colleagues. Learning to drop the defensiveness & move to dialogue.
- Sometimes it is hard not to get angry, especially when attacked.
- Frequently described as 'poker-face'
- I do not blow up but I will show irritation when I believe it to be justified. I likewise will repress this if necessary.

Q10. I am aware of my reactions

- No responses

Q11. I talk about the long-term vision

- No responses

Q12. I set goals that energize me

- If allowed to set the goals.
- I do try but can flounder when things get tough.

Q13. I express emotions appropriately

- Sometimes hide feelings.

Q14. I genuinely care about people

- not truly valued by the payers of healthcare, but are to patients/families and nurses

- People are the most fun.
- I used to really care but as our society deteriorates I am having more difficulty. Our society is losing accountability.

Q15. I am independent

- As independent as I can be. Nobody is completely independent.
- At my work I depend upon all the staff I work with.

Q16. I inspire others with my passion and commitment

- I hope so.
- I think I am a fairly good role model but do not believe I have the personality to be inspiring to others.
- I my thought. It is best to watch onlooker behavior to indeed assess this statement.

Q17. I am able to talk about what makes me anxious

- I tend to keep these thoughts to myself
- Generally I repress this
- Never had a problem with self expression.

Q18. I accurately explain why someone feels a particular way

- Hard to understand this question. Sort of like reading someone else's mind.
- This issue is fraught with risk since none of us read minds. We can only make reasonable assumptions or communicate with another person to explain why another person feels a particular way.
- I think I can assess peoples' reactions to situations fairly accurately.
- Highly variable aspect, I believe. Very dependent on the situation.

Q19. I adjust easily to new situations

- coping skill
- This is a necessary trait.
- One has to deal with reality

Q20. I consider the consequences of my behavior on others

- Not always, but I try.
- Sometimes I can be a little too pessimistic without realizing it.

Q21. I am able to explain my feelings

- sometimes

Q22. I recognize the “hot buttons” that provoke me

- Sometimes too late.
- It takes a lot to really make me mad so I am not sure I really have hot buttons.

Q23. I reflect before jumping to decisions

- Most of the time
- Sometimes I reflect a little too much which can delay decisions.

Q24. I manage my emotions effectively even in difficult situations

- Better at doing this in clinical situations, where I have training and are life and death, than I am with leadership...frustrated by behavior issues such as charge entry person standing on ceremony of ‘Medicare won’t pay so tell the doctors stop wri [respondent exceeded character limits]
- Even if I feel stressed out, I have been told my demeanor is calm.
- Most of the time.

Q25. I think of solutions even in challenging situations

- I really try at this.
- I am certainly willing to listen to suggestions in a difficult situation.

Q26. I motivate myself

- No response

Q27. I include others' feelings when making decisions

- Only if you want them to move with you and not against you.
- Try to. Not always
- toooooo much

Q28. I appropriately communicate about emotions with others

- To effectively manage, you need to check emotions at the door and use them as a tool, if I get anger or frustrated or the opposite, I risk alienating someone who may feel the same event in a different light.

Q29. I have integrity

- I hope so.
- In my best opinion.

Q30. I have an intuitive understanding of others

- I think so.
- I communicate well so I am able to get the sense of other people's feelings. Whether this is intuitive I am not sure.

Q31. I encourage others to be helpful

- Or discourage individuals who are unhelpful.

- I encourage team thinking.

Q32. I am truly interested in what others say

- I consider myself a good listener.

Appendix G

ANOVA Results

ANOVA Results

Enhancing Emotional Literacy (EEL)

- There was no significant effect of "hospital location" on EEL at the $p<.05$ level for the conditions [$F (2, 52) = 1.035$, $p = .362$].
- There was no significant effect of "number of inpatient beds in your hospital" on EEL at the $p<.05$ level for the conditions [$F (2, 51) = .160$, $p = .853$].
- There was no significant effect of "number of years as a physician" on EEL at the $p<.05$ level for the conditions [$F (2, 52) = 2.311$, $p = .109$].
- There was no significant effect of "number of years as a hospitalist" on EEL at the $p<.05$ level for the conditions [$F (2, 52) = .709$, $p = .497$].
- There was no significant effect of "number of years at your current organization" on EEL at the $p<.05$ level for conditions [$F (2, 52) = 1.495$, $p = .234$].
- There was no significant effect of "number of years in your current leadership role" on EEL at the $p<.05$ level for the conditions [$F (2, 52) = .650$, $p = .526$).
- There was no significant effect of "was your leadership position appointed or voluntary" on EEL at the $p<.05$ level for the conditions [$F (1, 53) = 2.739$, $p = .104$).
- There was no significant effect of "number of individuals that report directly to you" on EEL at the $p<.05$ level for the conditions [$F (2, 51) = .784$, $p = .462$).

Recognizing Patterns (RP)

- There was no significant effect of "hospital location" on RP at the $p<.05$ level for the conditions [$F (2, 52) = .099$, $p = .905$].

- There was no significant effect of "number of inpatient beds in your hospital" on RP at the p<.05 level for the conditions [F (2, 51) = 1.634, p = .205].
- There was no significant effect of "number of years as a physician" on RP at the p<.05 level for the conditions [F (2, 52) = 944, p = .396].
- There was no significant effect of "number of years as a hospitalist" on RP at the p<.05 level for the conditions [F (2, 52) = .019, p = .981].
- There was no significant effect of "number of years at your current organization" on RP at the p<.05 level for conditions [F (2, 52) = .731, p = .486].
- There was no significant effect of "number of years in your current leadership role" on RP at the p<.05 level for the conditions [F (2, 52) = .201, p = .818).
- There was no significant effect of "was your leadership position appointed or voluntary" on RP at the p<.05 level for the conditions [F (1, 53) = 1.523, p = .223).
- There was no significant effect of "number of individuals that report directly to you" on RP at the p<.05 level for the conditions [F (2, 51) = 1.120, p = .334).

Apply Consequential Thinking (ACT)

- There was no significant effect of "hospital location" on ACT at the p<.05 level for the conditions [F (2, 52) = 1.350, p = .268].
- There was no significant effect of "number of inpatient beds in your hospital" on ACT at the p<.05 level for the conditions [F (2, 51) = .185, p = .832].
- There was no significant effect of "number of years as a physician" on ACT at the p<.05 level for the conditions [F (2, 52) = 1.035, p = .362].

- There was no significant effect of "number of years as a hospitalist" on ACT at the $p<.05$ level for the conditions [$F (2, 52) = .051$, $p = .950$].
- There was no significant effect of "number of years at your current organization" on ACT at the $p<.05$ level for conditions [$F (2, 52) = .960$, $p = .390$].
- There was no significant effect of "number of years in your current leadership role" on ACT at the $p<.05$ level for the conditions [$F (2, 52) = .394$, $p = .676$).
- There was no significant effect of "was your leadership position appointed or voluntary" on ACT at the $p<.05$ level for the conditions [$F (1, 53) = 1.928$, $p = .171$).
- There was a significant effect of "number of individuals that report directly to you" on ACT at the $p<.05$ level for the conditions [$F (2, 51) = 3.319$, $p = .044$).

Navigating Emotions (NE)

- There was no significant effect of "hospital location" on NE at the $p<.05$ level for the conditions [$F (2, 52) = .685$, $p = .508$].
- There was no significant effect of "number of inpatient beds in your hospital" on NE at the $p<.05$ level for the conditions [$F (2, 51) = .811$, $p = .450$].
- There was no significant effect of "number of years as a physician" on NE at the $p<.05$ level for the conditions [$F (2, 52) = .239$, $p = .788$].
- There was no significant effect of "number of years as a hospitalist" on NE at the $p<.05$ level for the conditions [$F (2, 52) = .196$, $p = .823$].
- There was no significant effect of "number of years at your current organization" on NE at the $p<.05$ level for conditions [$F (2, 52) = .281$, $p = .756$].

- There was no significant effect of "number of years in your current leadership role" on NE at the p<.05 level for the conditions [F (2, 52) = .783, p = .462).
- There was no significant effect of "was your leadership position appointed or voluntary" on NE at the p<.05 level for the conditions [F (1, 53) = 2.389, p = .128).
- There was no significant effect of "number of individuals that report directly to you" on NE at the p<.05 level for the conditions [F (2, 51) = 1.363, p = .265).

Engage Intrinsic Motivation (EIM)

- There was no significant effect of "hospital location" on EIM at the p<.05 level for the conditions [F (2, 52) = 1.272, p = .289].
- There was no significant effect of "number of inpatient beds in your hospital" on EIM at the p<.05 level for the conditions [F (2, 51) = .478, p = .623].
- There was no significant effect of "number of years as a physician" on EIM at the p<.05 level for the conditions [F (2, 52) = 1.231, p = .300].
- There was no significant effect of "number of years as a hospitalist" on EIM at the p<.05 level for the conditions [F (2, 52) = .833, p = .440].
- There was no significant effect of "number of years at your current organization" on EIM at the p<.05 level for conditions [F (2, 52) = .481, p = .621].
- There was no significant effect of "number of years in your current leadership role" on EIM at the p<.05 level for the conditions [F (2, 52) = .114, p = .892).
- There was no significant effect of "was your leadership position appointed or voluntary" on EIM at the p<.05 level for the conditions [F (1, 53) = 940, p = .337).

- There was no significant effect of "number of individuals that report directly to you" on EIM at the p<.05 level for the conditions [F (2, 51) = .432, p = .652).

Exercise Optimism (EO)

- There was no significant effect of "hospital location" on EO at the p<.05 level for the conditions [F (2, 52) = .332, p = .719].
- There was no significant effect of "number of inpatient beds in your hospital" on EO at the p<.05 level for the conditions [F (2, 51) = 1.098, p = .341].
- There was no significant effect of "number of years as a physician" on EO at the p<.05 level for the conditions [F (2, 52) = .106, p = .899].
- There was no significant effect of "number of years as a hospitalist" on EO at the p<.05 level for the conditions [F (2, 52) = .576, p = .565].
- There was no significant effect of "number of years at your current organization" on EO at the p<.05 level for conditions [F (2, 52) = .448, p = .642].
- There was no significant effect of "number of years in your current leadership role" on EO at the p<.05 level for the conditions [F (2, 52) = .380, p = .686).
- There was no significant effect of "was your leadership position appointed or voluntary" on EO at the p<.05 level for the conditions [F (1, 53) = 3.395, p = .071).
- There was no significant effect of "number of individuals that report directly to you" on EO at the p<.05 level for the conditions [F (2, 51) = 3.019, p = .057).

Increase Empathy (IE)

- There was no significant effect of "hospital location" on IE at the p<.05 level for the conditions [F (2, 52) = .243, p = .785].

- There was no significant effect of "number of inpatient beds in your hospital" on IE at the $p<.05$ level for the conditions [$F (2, 51) = 1.555$, $p = .221$].
- There was no significant effect of "number of years as a physician" on IE at the $p<.05$ level for the conditions [$F (2, 52) = 1.437$, $p = .2247$].
- There was no significant effect of "number of years as a hospitalist" on IE at the $p<.05$ level for the conditions [$F (2, 52) = .742$, $p = .481$].
- There was no significant effect of "number of years at your current organization" on IE at the $p<.05$ level for conditions [$F (2, 52) = .505$, $p = .606$].
- There was no significant effect of "number of years in your current leadership role" on IE at the $p<.05$ level for the conditions [$F (2, 52) = 2.603$, $p = .084$).
- There was no significant effect of "was your leadership position appointed or voluntary" on IE at the $p<.05$ level for the conditions [$F (1, 53) = 1.611$, $p = .210$).
- There was no significant effect of "number of individuals that report directly to you" on IE at the $p<.05$ level for the conditions [$F (2, 51) = .936$, $p = .399$).

Appendix H

Ranking of Means: Importance (Largest to Smallest)

Ranking of Means: Importance (Largest to Smallest)

Item	Mean
I have integrity	4.90
I genuinely care about people	4.83
I take responsibility for solving problems instead of blaming	4.73
I make decisions based on important values	4.72
I think of solutions even in challenging situations	4.69
I motivate myself	4.68
I consider the consequences of my behavior on others	4.60
I reflect before jumping to decisions	4.60
I manage my emotions effectively even in difficult situations	4.60
I am proactive take action without having to be pushed by others	4.59
I encourage others to be helpful	4.59
I am aware of my reactions	4.58
I am truly interested in what others say	4.58
I inspire others with my passion and commitment	4.56
I notice others feelings	4.54
I talk about the long term vision	4.54
I include others feelings when making decisions	4.51
I manage my reactions skillfully	4.47
I am independent	4.47
I adjust easily to new situations	4.47
I set goals that energize me	4.44
I express emotions appropriately	4.37
I have an intuitive understanding of others	4.37
I recognize the hot buttons that provoke me	4.36
I accurately describe my own behavior	4.29
I see the best in situations	4.25
I am able to explain my feelings	4.17
I discuss the emotional impact of decisions	4.07
I accurately explain why someone feels a particular way	4.03
I appropriately communicate about emotions with others	4.00
I use a wide variety of feeling words	3.95
I am able to talk about what makes me anxious	3.88

Appendix I

Ranking of Means: Performance (Largest to Smallest)

Ranking of Means: Performance (Largest to Smallest)

Item	Mean
I have integrity	4.78
I genuinely care about people	4.66
I make decisions based on important values	4.64
I take responsibility for solving problems instead of blaming	4.54
I think of solutions even in challenging situations	4.49
I motivate myself	4.47
I notice others feelings	4.41
I consider the consequences of my behavior on others	4.41
I am truly interested in what others say	4.41
I am proactive take action without having to be pushed by others	4.36
I include others feelings when making decisions	4.31
I encourage others to be helpful	4.31
I am independent	4.29
I am aware of my reactions	4.28
I talk about the long term vision	4.27
I reflect before jumping to decisions	4.26
I inspire others with my passion and commitment	4.25
I accurately describe my own behavior	4.22
I set goals that energize me	4.22
I have an intuitive understanding of others	4.17
I adjust easily to new situations	4.15
I manage my emotions effectively even in difficult situations	4.10
I use a wide variety of feeling words	4.07
I see the best in situations	4.05
I manage my reactions skillfully	4.05
I express emotions appropriately	4.03
I recognize the hot buttons that provoke me	4.02
I am able to explain my feelings	4.00
I discuss the emotional impact of decisions	3.95
I accurately explain why someone feels a particular way	3.76
I appropriately communicate about emotions with others	3.75
I am able to talk about what makes me anxious	3.69

Appendix J

Ranking of Gaps (Largest to Smallest)

Ranking of Gaps (Largest to Smallest)

	Mean Importance	Mean Performance	Diff.
I manage my emotions effectively even in difficult situations	4.60	4.10	0.50
I manage my reactions skillfully	4.47	4.05	0.42
I express emotions appropriately	4.37	4.03	0.34
I recognize the hot buttons that provoke me	4.36	4.02	0.34
I reflect before jumping to decisions	4.60	4.26	0.34
I adjust easily to new situations	4.47	4.15	0.32
I inspire others with my passion and commitment	4.56	4.25	0.31
I am aware of my reactions	4.58	4.28	0.30
I encourage others to be helpful	4.59	4.31	0.28
I talk about the long term vision	4.54	4.27	0.27
I accurately explain why someone feels a particular way	4.03	3.76	0.27
I appropriately communicate about emotions with others	4.00	3.75	0.25
I am proactive take action without having to be pushed by others	4.59	4.36	0.23
I set goals that energize me	4.44	4.22	0.22
I motivate myself	4.68	4.47	0.21
I see the best in situations	4.25	4.05	0.20
I think of solutions even in challenging situations	4.69	4.49	0.20
I include others feelings when making decisions	4.51	4.31	0.20
I have an intuitive understanding of others	4.37	4.17	0.20
I take responsibility for solving problems instead of blaming	4.73	4.54	0.19
I am able to talk about what makes me anxious	3.88	3.69	0.19
I consider the consequences of my behavior on others	4.60	4.41	0.19
I am independent	4.47	4.29	0.18
I genuinely care about people	4.83	4.66	0.17
I am able to explain my feelings	4.17	4.00	0.17
I am truly interested in what others say	4.58	4.41	0.17
I notice others feelings	4.54	4.41	0.13
I discuss the emotional impact of decisions	4.07	3.95	0.12
I have integrity	4.90	4.78	0.12

Ranking of Gaps (Largest to Smallest) continued

	Mean Importance	Mean Performance	Diff.
I make decisions based on important values	4.72	4.64	0.08
I accurately describe my own behavior	4.29	4.22	0.07
I use a wide variety of feeling words	3.95	4.07	-0.12